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HOSPITAL TOPICS

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WITH THE **Buyer's Guide**

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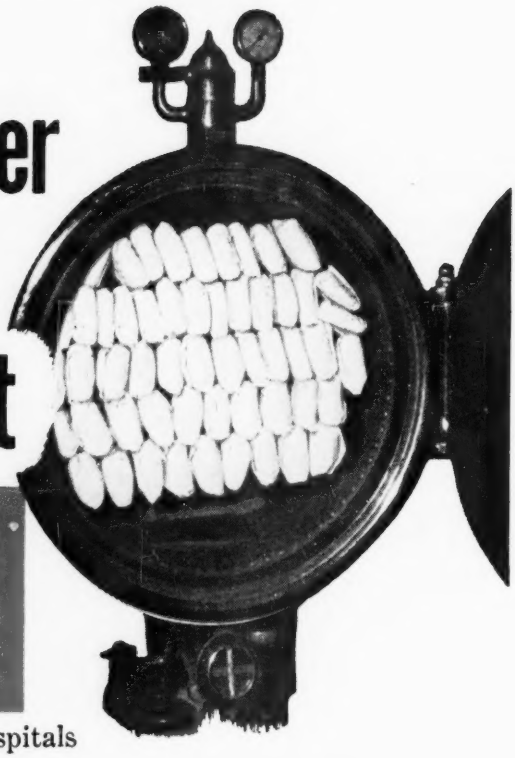
ALFRED E. MAFFY, Administrator, Herrick Memorial Hospital, Berkeley, Calif. (see page 3)

FEBRUARY
1 9 5 3

how did we ever manage without



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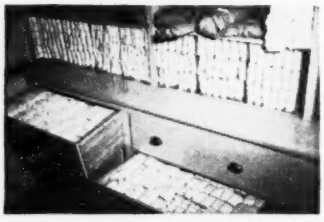

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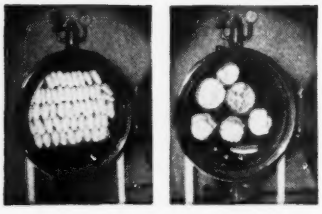

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HOSPITAL TOPICS

with the Buyer's Guide

February, 1953

The News Magazine for the Hospital Staff

Vol. XXXI, No. 2

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Personality of the Month

Alfred E. Maffly

Administrator
Herrick Memorial Hospital
Berkeley, Calif.

● Appointed administrator of Herrick Memorial Hospital in 1933, Alfred E. Maffly has since participated in its growth from 50 beds to the 201-bed institution it is today.

Mr. Maffly has two driving convictions: First: that each community hospital should consider its expansion into a complete medical center with comprehensive facilities for prevention, diagnosis, and treatment of the sick, for both in-patients and out-patients, and for both private and clinic patients. Second: that every hospital should participate in medical education and research in accordance with its size, its location, and its opportunities.

Results of these convictions are apparent at Herrick. As part of the medical center pattern, Herrick has established an emergency hospital for four surrounding cities; set up part-pay clinics for the East Bay area; developed facilities for post-polio patients; and instituted a chest unit for tubercular patients who require surgical and other general hospital care. Herrick was one of the first private general hospitals in California to open a psychiatric unit and to develop a department of dentistry and oral surgery. Next on the list is the establishment of a Rehabilitation Center and development of a professional building.

Mr. Maffly is a lecturer in hospital administration in the Schools of Public Health at the University of California and Columbia University.

He is a fellow of the ACHA; second vice president, California Hospital Association; chairman, Committee on Institutes, Association of Western Hospitals; member, AHA, and first president, California Chapter, American Association of Hospital Accountants.

His hobbies are gardening, philately, music, reading, and travel. An ardent convention attender, he feels his most fascinating was the International Hospital Federation Congress in Brussels which gave him the opportunity to visit many of the hospitals in Western Europe.

Mr. Maffly is married and has a family of three children and two grandchildren.

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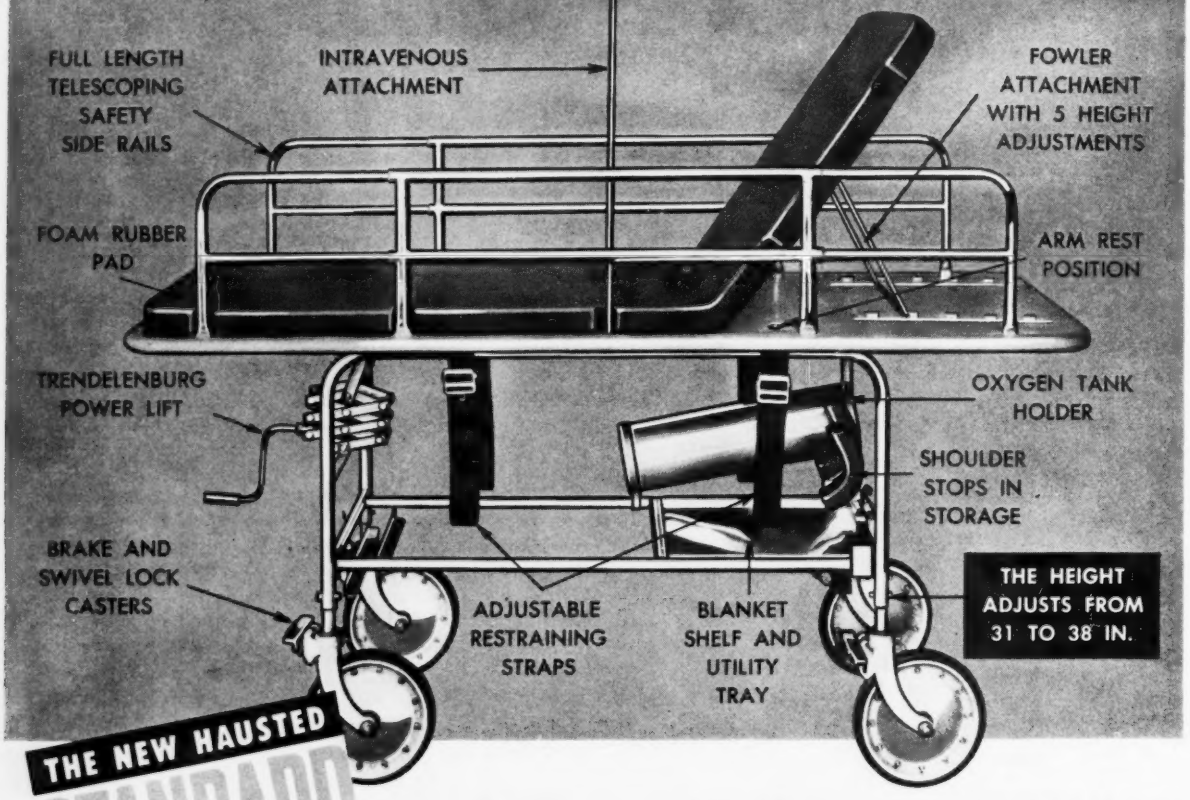
SUPERIORITY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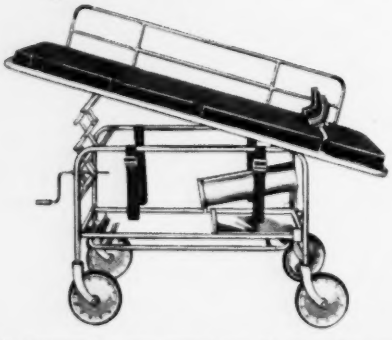

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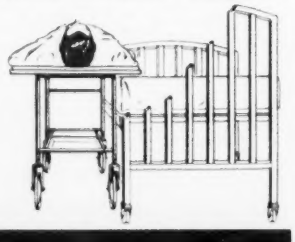

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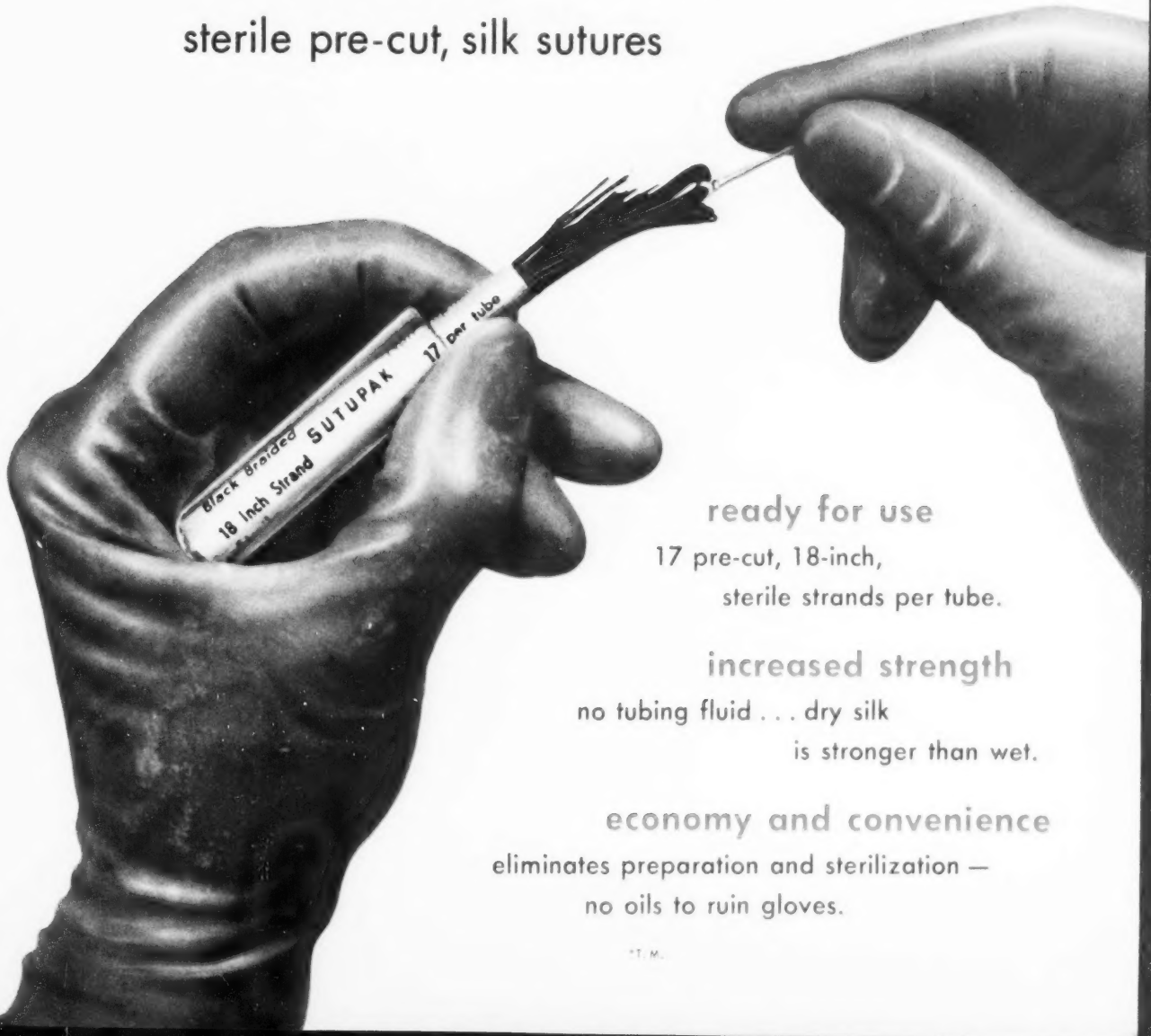

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News Letter

● Gamma globulin, which reduces effects of paralytic polio, will be under control of a panel of experts headed by Hugh Leavell, M.D., Harvard School of Public Health. Other appointees to allocation panel are: John Porterfield, M.D., and Bruce Underwood, M.D., state health officers of Ohio and Kentucky, respectively; William McD. Hammon, M.D., Pittsburgh, who worked on field studies; Thomas P. Murdock, M.D., Meriden, Conn., AMA trustee; James Shannon, M.D., National Institutes of Health, and a representative of the government's Communicable Disease Center, Altanta.

● Opening of 83rd Congress brought usual flood of new bills, including many of medical interest. But no significant action is expected until after the Eisenhower administration gets its bearings, and committees become familiar with the problems.

● Most bills were old standbys. Examples: one to create a Department of Health; one to provide federal hospital benefits for dependents of servicemen and for elderly persons receiving social security payments. For first time in years, no bill on national health insurance was introduced during opening week of a new Congress. Although that issue is practically dead, more and more Capitol Hill-dwellers seemingly are becoming convinced of need of federal assistance to state governments to facilitate increased coverage in voluntary health programs.

● Proposed revisions can be expected soon in budget handed to Congress by outgoing administration. Truman budget calls for continued federal spending for health programs, at about the present level. About $2.7 billion is set aside for health and welfare spending during the fiscal year 1954. Hill-Burton program is budgeted for $75 million—same as its 1953 allotment—but various institutes of health are scheduled to receive $11 million increase, or a total of $70 million. Additional money is for support of research in universities and other nonprofit institutions, and for clinical center opening at Bethesda this spring.

● Fate of the plan developed by President Truman's Commission on Health Needs of the Nation seems to depend largely on President Eisenhower and the AMA. Feeling among some senators is that if AMA fights plan as hard as it did compulsory health insurance, getting aproval would be almost impossible. On the other hand, some of same sources predict that if Eisenhower gives his endorsement to plan and says he wants it to go through, it will.

● AMA issued sharply critical blast against Social Security Administration's report that insurance covered only 13 percent of the American public's $14.2 billion health expenses in 1951. George Lull, M.D., AMA secretary and general manager, termed the report "a perversion of statistical information," presented in such a way as to imply need for compulsory health insurance. To give an honest picture of value of voluntary insurance, Dr. Lull declared, report should have determined amount of dollar benefits paid in proportion to total health bills of only those covered by health insurance. Study did not consider, he stated, other sources of payment of medical bills, such as workmen's compensation insurance, liability insurance, accident insurance, life insurance, community and governmental agencies, and private philanthropic and health foundations.

● More than half the U. S. population had some insurance protection against sickness in 1951, report said. Policyholders paid $2.4 billion in premiums and got back $1.8 billion in benefits. Hospitalization benefits were 66 percent of the 1951 total (compared with 75 percent in 1948).

● Thoughtful editorial on challenges to existing medical system appears in Jan. 17 issue of the Journal of the AMA. Three "challenges of the future," it says, are: (1) changing meaning of socialism (with emphasis not on government ownership but on governmental control); (2) effect of aging on the voting population (one result: increasingly heavier demands for old age benefits), and (3) need for voluntary health insurance to serve an aging population. Some way must be found, editors say, for citizens to pay during their working years for health care after retirement.

Gordon H. Marshall

PRESCRIPTION PAD

New Contrast Medium for X-Ray

Urokon Sodium 70 percent, a new, concentrated radiopaque medium for x-ray diagnosis, is announced by Mallinckrodt Chemical Works.

The new product supplements Urokon Sodium 30 percent, which the company will continue to supply. The 70 percent solution has unusual opacity to x-rays due to its high iodine content, each cc. containing 461 mg. of iodine in organic combination.

Two years of clinical study in several thousand cases have demonstrated the notable safety of the higher concentration. The new product extends the applications of the medium to angiocardiography, nephrography, and translumbar arteriography, although intravenous urography is probably the greatest field of usefulness for both the 30 percent and the 70 percent solutions. The fact that as much as 50 cc. of the 70 percent solution is injected intravenously within a few seconds in angiocardiographic and nephrographic procedures emphasizes the exceptionally low toxicity of the radiopaque organic iodine compound.

Clinicians who have studied the medium point out that the 70 percent solution provides intravenous urograms of such good contrast that confirmatory retrograde examinations are frequently unnecessary. Elimination of this procedure is considered a desirable end in itself by urologists.

New Ophthalmic Ointment

Neosone is a well-tolerated ophthalmic ointment containing cortisone and neomycin.

The ointment base melts rapidly at the temperature of the eye and mixes readily with tear secretions. This promotes rapid spread of the finely-divided particles of cortisone and neomycin.

Neosone has a dual action. Cortisone applied locally relieves inflammation and is the therapy of choice in inflammatory conditions affecting the anterior segment of the eye. Neomycin prevents or combats infection, has a wide range of antibacterial activity, is antibacterial in low concentrations, and is not inactivated by exudates.

Neosone is well tolerated and relieves the inflammation caused by allergy, trauma, and infection, as well as attacking the organisms responsible for infection. It is indicated in the treatment of various forms of conjunctivitis, keratitis, marginal ulceration, and mechanical, thermal or chemical trauma.

Neosone is an Upjohn product, supplied in one-dram tubes, with applicator tip.

For Ear Infections

Tyotocin, a new antibacterial and antimycotic treatment of ear infections, is announced by Sharp & Dohme.

Tyotocin is recommended in the treatment of mycotic and bacterial infections of the external auditory canal, such as otitis externa, furunculosis and secondarily infected eczema. It is also indicated for relief from pain and congestion in acute otitis media when the ear drum is intact.

Tyrothricin and hexylresorcinol are two powerful agents in this new product which possess antifungal and antibacterial properties. In combination the two agents exert a synergistic effect *in vitro* against Staphylococcus aureus. Effective relief from pain and itching are provided by antipyrine and benzocaine. Hexylresorcinol also possesses mild analgesic properties. Hygroscopic activity of anhydrous propylene glycol and anhydrous glycerin results in withdrawal of fluid from the surrounding inflamed tissue. The result is relief from pain due to congestion caused by mucoid or purulent discharge.

Tyotocin Ear Drops are supplied in 15 cc. (½ fl. oz.) bottles with dropper assembly.

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CLINICAL NOTES

By James F. Fleming, M.D.

Alcohol-Oxygen Inhalation in Pulmonary Edema

Utilizing the non-foaming action of alcohol vapor, Goldmann and Luisada, of Chicago, report on a successful method of treating pulmonary edema, in *Annals of Internal Medicine*, December, 1952.

Several methods of administration were tried, and the most suitable was found to be the use of a nasal catheter and 95 percent alcohol for conscious patients, and a mask and 30 to 40 percent alcohol for unconscious patients.

In 12 of 14 attacks in which alcohol-oxygen was used as the only medication, results were excellent. Maximal benefit usually occurred in an hour.

In 23 attacks alcohol-oxygen was used after failure of conventional therapy. Improvement which could definitely be attributed to the inhalation therapy occurred in 15; in six others there was improvement which could have been partially attributed to other medication.

The overall mortality in acute pulmonary edema was seven deaths among 35 patients (representing 40 attacks). In five of the fatal cases, pulmonary edema was relieved before death.

The authors consider ethyl alcohol by inhalation as the method of choice in patients with shock, including coronary patients, in central nervous system lesions, and in pregnancy. It can be used in conjunction with other methods.

The Prothrombin at Birth

The mechanism of hypoprothrombinemia is not well understood, although it is generally recognized that the condition develops with ease in the newborn. Quick, Murat and Hussey, of Milwaukee, attempted to determine at least part of the mechanism in a study in which the prothrombin levels were investigated in the mother, in the cord, and in the baby soon after birth. Their results are reported in abstract form in the *Journal of Laboratory and Clinical Medicine*, December, 1952.

The authors found that administration of vitamin K to the mother caused a normal prothrombin time in mother, cord and baby. When no vitamin K was given, the prothrombin time was low in baby and cord, and sometimes in the mother.

The total prothrombin of the baby, when the prothrombin time was normal, averaged only a fourth of the amount which is considered normal for the adult. The suggestion is made by the authors that the infant has only free prothrombin, and none at all in the inactive, or reserve, form, which is prothrombinogen.

It is possible that a temporary lack of vitamin K is responsible for the low prothrombin often seen in newborn infants. The vitamin is poorly absorbed, and even an adequate diet of the mother may not meet the fetal requirements for this reason.

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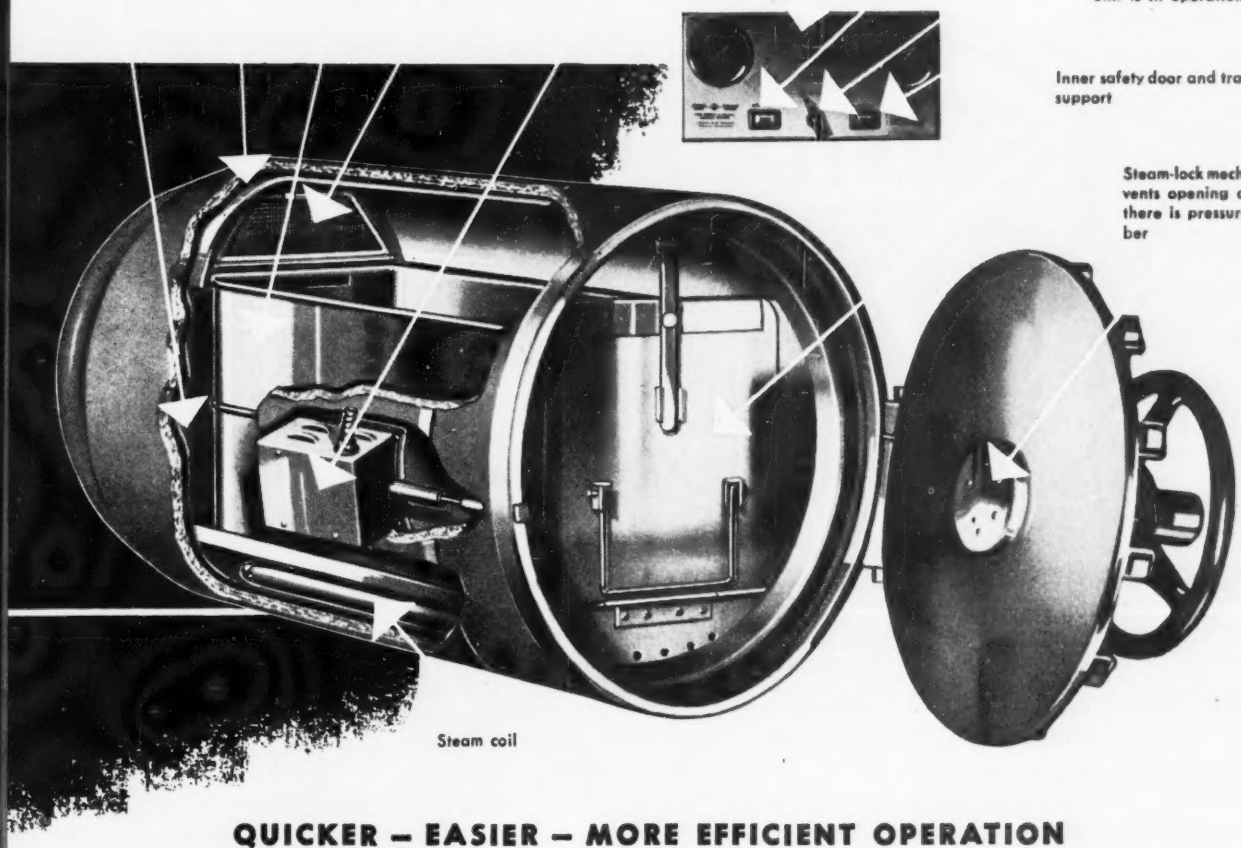
On-Off switch

Second visual light signal informs operator when unit is in operation



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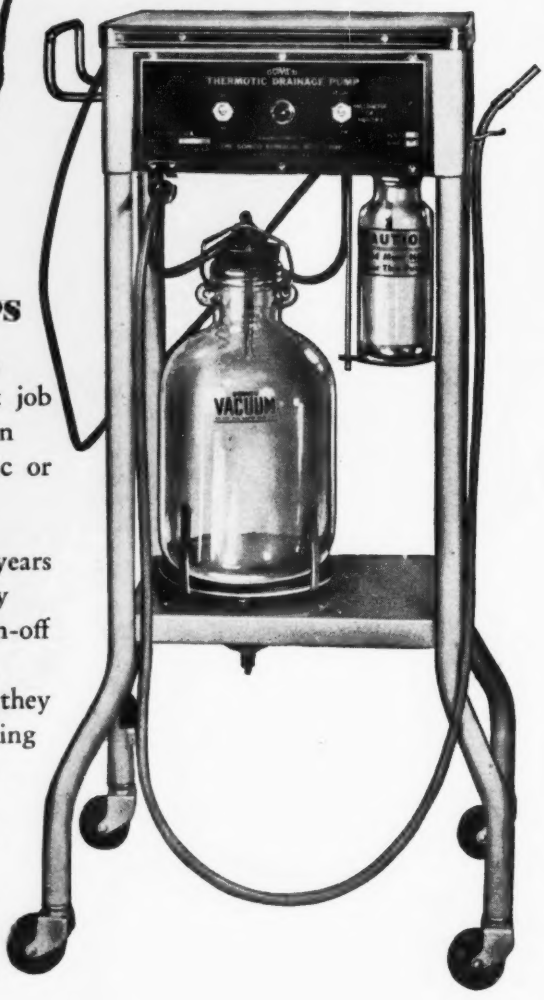

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[1]NURSING ARTS, Mildred L. Montag, M.A., R.N., Margaret Filson, M.A., R.N., Saunders, 1948: p. 237

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FEBRUARY

6- 7 AHA Midyear Conference
Drake Hotel, Chicago
10-13 Protestant Hospital Assn.
Palmer House, Chicago
11-12 National Assn. of Methodist Hospitals and Homes
Palmer House, Chicago
12-14 Arizona Hospital Assn.
Adams Hotel, Phoenix
19 Wisconsin Hospital Assn.
Schroeder Hotel, Milwaukee
20-21 Georgia Hospital Assn.
Atlanta Biltmore Hotel, Atlanta

MARCH

23-25 New England Hospital Assembly
Statler Hotel, Boston
23-26 American Academy of General Practice, Kiel Auditorium, St. Louis
24-26 Kentucky Hospital Assn.
Louisville

APRIL

6- 9 Ohio Hospital Assn.
Netherland Plaza Hotel, Cincinnati
8-10 Southeastern Hospital Conference
Jung Hotel, New Orleans
13-17 Mid-West Hospital Assn.
Kansas City, Mo.
23-25 World Medical Assn.
Richmond, Va.
27-30 Assn. of Western Hospitals
Hotel Utah, Salt Lake City

MAY

2- 9 Carolinas-Virginia Hospital Conference Cruise from Norfolk, Va., to Bermuda and return
4- 6 Tri-State Hospital Assembly
Palmer House, Chicago
5 World Health Organization, Geneva, Switzerland
8-11 Tennessee Hospital Assn.
Andrew Jackson Hotel, Nashville
11-13 Aero Medical Assn.
Biltmore Hotel, Los Angeles
12-14 Texas Hospital Assn.
Buccaneer Hotel, Galveston
20-22 Middle Atlantic Hospital Assembly
Convention Hall, Atlantic City
20-22 New Jersey Hospital Assn.
Convention Hall, Atlantic City
25-30 International Hospital Federation
London
25-28 Catholic Hospital Assn., Kansas City, Mo.

JUNE

1- 5 American Medical Assn.
New York City
14-18 American Society of Medical Technologists, Louisville
14-20 Physical Therapy Assn.
Baker Hotel, Dallas
22-26 National League for Nursing
Auditorium, Cleveland

AUGUST

25-28 American Dietetic Assn., Shrine Civic Auditorium, Los Angeles
31-Sept. 3 AHA Convention
San Francisco
31-Sept. 6 World Medical Assn. 7th Assembly, Amsterdam, Holland

OCTOBER

5-9 American Assn. of Medical Record Librarians, Palace Hotel, San Francisco
12-13 Alabama Hospital Assn.
Jefferson Davis Hotel, Montgomery

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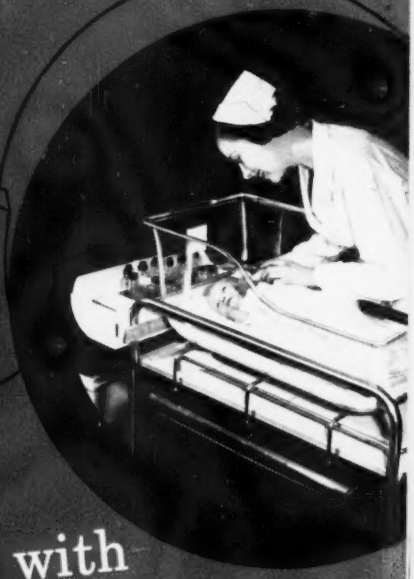

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IN BRIEF:

Current, important literature

"SHARING LIBRARY SERVICE"—Anne Maxville, American Journal of Nursing, January, 1952, p. 66. System adopted by two schools of nursing might be applied in two small hospitals which are close enough together to make sharing of library service feasible. Time and money are saved by ordering books for both schools at the same time. There is a free exchange of books between the libraries, which also have inter-library loan system with three different types of libraries in the community.

"PREPARING FOR THE VISITING DOCTOR"—Stuart Covington, Southern Hospitals, December, 1952, p. 28. "Visitor's office" should be a must for both large and small hospitals. Time of visitor and of hospital staff is saved by having even a very small space reserved for out-of-town consultants.

"COORDINATION OF NURSING AND PHARMACY DEPARTMENTS"—Dorothy M. Morgan, R.N., The Bulletin, American Society of Hospital Pharmacists, November-December, 1952. Mutual advantages to nursing and pharmacy departments can be derived from: providing adequate messenger service from pharmacy, so that nurses will not have to take time from nursing duties; eliminating all pharmaceutical work by nurses; keeping nurses' accounting duties to a minimum by adopting simple, effective charge system for drugs; education of student and graduate nurses by pharmacy department.

"THE CLEVELAND HEALTH MUSEUM'S PROGRESS TOWARD PATIENT EDUCATION"—Bruno Gebhard, M.D., Journal of the AMA, Dec. 20, 1952, p. 1594. Museum's program, in 12-year history, has had increasing acceptance from health-conscious public. Exhibits presented are scientific and non-controversial. Since patient is actually first diagnostician of his own illness, patient education is most important part of public health education. Individual physician has primary responsibility for patient education, but hospitals owe it to their patients to have organized educational programs.

"CARDIAC SURGERY IN A COMMUNITY GENERAL HOSPITAL"—Nicholas A. Antonius, M.D., Harold A. Murray, M.D., Bernard A. O'Connor, M.D., and Anthony D. Crecca, M.D., Journal of the AMA, Jan. 3, 1953, p. 8. Community hospital can have advantage of knowledge of new technics in cardiac surgery, if administrator and staff are aggressive in seeking help from leaders in medical centers. This hospital inaugurated teaching program which brought in outstanding cardiologists to educate local staff physicians. Group conferences for diagnosis and treatment proved most beneficial to patients.

"CONSTRUCTION OF HOSPITALS, HEALTH CENTERS, AND OTHER HEALTH FACILITIES, 1951-52"—Wesley E. Gilbertson and Harold A. Kahn, Public Health Reports, December, 1952, p. 1168. Construction of civilian health facilities has not been set back seriously under the controlled materials plan, but civilian health facilities were allocated much smaller quantities of materials than needed during 1951-52. Conservation policy helped distribute available materials and prevent a number of disapproved applications. Report includes charts on beds existing and beds needed.

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22 x 40, 22 x 45, 22 x 50, 24 x 30, 24 x 40, 24 x 50	2.25	2.20	2.12	2.10	2.04
No. 6649 2—No. 2 Thickness					
15 x 15	2.10	1.89	1.79	1.73	1.68
18 x 18	1.93	1.74	1.64	1.59	1.54
22 x 22, 22 x 30, 22 x 40, 22 x 45, 22 x 50, 24 x 30, 24 x 40, 24 x 50	1.75	1.58	1.49	1.45	1.40
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12	5.76	5.18	4.90	4.75	4.61
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18	4.53	4.08	3.85	3.74	3.62
22 & 25	4.11	3.70	3.49	3.39	3.29
No. 6649 6—Circle No. 2 Thickness Diameter MM.					
12	4.29	3.86	3.65	3.54	3.43
15	3.68	3.31	3.13	3.04	2.94
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3. Pneumococci	Empyema, lobar pneumonia
4. Corynebacterium diphtheriae	Diphtheria carriers
5. Nonhemolytic streptococci	Some cases of endocarditis, genito-urinary tract infections

***References**

1. Heilman, F. R., Herrell, W. E., Wellman, W. E., and Geraci, J. E.: Some Laboratory and Clinical Observations on a New Antibiotic, Erythromycin ('Ilotycin'), Proc. Staff Meet., Mayo Clin., 27:285 (July 16), 1952. 2. Haight, T. H., and Finland, M.: Laboratory and Clinical Studies on Erythromycin, New England J. Med., 247:227 (August 14), 1952. 3. Smith, J. W., Dyke, R. W., and Griffith, R. S.: Erythromycin: Studies on Absorption Following Oral Administration and on Treatment of 33 Patients, to be published. 4. Spink, W. W.: Personal communications. 5. Romansky, M. J.: Personal communications.

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Scanning the News

Ski-Shaped Needle Devised to Suture Mitral Incisions

Development of a new kind of surgical needle, to be used in suturing incisions of the mitral valve, was announced recently by Gerald H. Pratt, M.D., New York City.

Dr. Pratt is associated with the vascular clinic of St. Vincent's Hospital and the New York University College of Medicine.

The ski-shaped needle was made with the base of the ski as a long square, instead of a flat surface, as in most surgical needles, Dr. Pratt reported in an article in the *Journal of the AMA*. The change in design, he said, permits the needle to be held securely at any angle and makes suturing less hazardous. The needle is believed suitable for other deep suturing.

• • •

Study Cyanide's Role in Multiple Sclerosis

The discovery that multiple sclerosis victims have a uniformly high level of cyanide in their blood is causing scientists to speculate about the role of the poison in the disease.

Initial symptoms of multiple sclerosis are very similar to the symptoms of cyanide poisoning. Sodium thiosulfate, a common antidote for cyanides, quickly reduces the blood level of cyanide in multiple sclerosis patients, but whether or not it has any effect on the outcome of the disease has not been determined.

Cyanides are not the cause of multiple sclerosis, emphasizes Richard C. Fowler, M.D., University of Rochester School of Medicine and Dentistry. He suggests, however, that the presence of cyanide may be related to the nerve scarring which is the cause of symptoms in the disease.

• • •

Siamese Twins' Operation Recorded by Artist

A complete pictorial record of the operation which separated the Brodie Siamese twins will be available to doctors of the future, thanks to the medical illustration department of the University of Illinois.

A staff artist was assigned to cover the 12-hour operation. He sketched rapidly and filled in details afterward. Motion pictures also were taken of the event.

Dr. Ivy Granted Leave; Will Study Cancer Drug

Andrew C. Ivy, M.D., Ph.D., center of a controversy over the drug krebiozen, has been granted a six-month leave without pay from his position as vice-president of the University of Illinois, in charge of Chicago professional colleges.

• • •

Coenzymes Synthesized by British Scientists

Three coenzymes — the biochemical "spark plugs" in the engine of the life cell — have been synthesized by a group of researchers at the University Chemical Laboratories, London.

The scientists' work, a laboratory triumph, will be of great importance when physiologists and pathologists determine the exact relationship of the coenzymes with the growth both of healthy and of malignant cells, as well as with the development of viruses and bacteria.

It is thought that there are about six of the complex substances. Some vitamins, especially members of the vitamin B family, are known to form the active part of the coenzymes.

(Continued on next page)

Principal speakers at the recent semi-annual meeting of the American Surgical Trade Association in New York City were Madison B. Brown, M.D. (l.) executive vice-president, Roosevelt Hospital, New York City, and George Bugbee (r.), executive director, American Hospital Association, Chicago. With Dr. Brown and Mr. Bugbee are ASTA officers Robert C. Blackwood (second from l.), treasurer, and Robert E. Anderson, Jr., president.

Increased Services Given Handicapped

Services for the handicapped continued to increase during 1952, but the need for such services grew much more rapidly.

Sixty-seven thousand persons were rehabilitated through federal-state programs in the fiscal year ending in June, 1952, the Office of Vocational Rehabilitation reported recently.

Because of their increased earning ability, it is estimated that within four years the rehabilitated persons will pay back in income taxes all of the $21,000,000 spent by the federal government for the vocational rehabilitation program.

About 2,000,000 persons now need rehabilitation services, according to the Office of Defense Mobilization, and 250,000 persons are added to this group every year, as the result of accidents.

• • •

Strange Fish May Add to Evolution Knowledge

Discovery of a coelacanth, member of a fish family that is 300,000,000 years old, is expected to give scientists new clues to the first evolutionary development of man.

Until 1938, when a coelacanth was discovered near South Africa, it was believed that these fish became extinct 75,000,000 years ago. The specimen recently captured is in better condition for study than that found in 1938.

• • •

Chlorophyll May Harm, Warns Noted Chemist

Commercial chlorophyll preparations cannot perform all the miracles advertisers claim for them, and may be dangerous if taken in excessive quantities, according to Alsoph H. Corwin, Ph.D., head of the department of chemistry, Johns Hopkins University.

Some of the preparations, which are copper derivatives of the natural substance, contain considerably more copper than the amount of the derivative in the sample, and cause chemists to suspect that an overdose would lead to liver damage.

Value of these preparations as deodorants was denied by Dr. Corwin, who pointed out that the substances cannot be distributed throughout the body in amounts sufficient to affect perspiration odors.

University Studies Problems of Aged

Problems of old age and retirement are being studied at a Florida trailer park by University of Chicago scientists.

The park is part of a research project undertaken by the university's industrial relations center and Ernest W. Burgess, emeritus professor of sociology. The university also is studying conditions in Moosehaven, a north Florida community founded for aged persons by the Moose lodge about 20 years ago.

When couples arrive at the trailer park, their backgrounds and personalities will be studied, and then they will be observed as they adjust themselves to trailer park living.

• • •

Radioactive Beads Help Fight Heart Disease

Colored, radioactive plastic beads are being used in studies on heart failure at the UCLA School of Medicine and the West Los Angeles VA Center.

The beads, injected into the coronary arteries of experimental animals, simulate a certain kind of blood clot. The resulting shock condition is almost identical with that involved in human heart failure.

• • •

Treatment Helps Sex Offenders

Success of a new program of treatment of sex deviates is reported by the Norwalk (Calif.) State Hospital.

Of the 50 patients released in the last two years, only one has returned for treatment. Formerly nine out of 10 sex offenders released from the hospital had to be returned because they had repeated their offenses.

Periods of hospitalization have been from one to two years. Treatment chosen varies with the individual and with the cause of his difficulties.

• • •

At a Glance . . . The 2,200-ton cosmotron of the Brookhaven National Laboratory was formally dedicated at Upton, L. I., recently. . . . Establishment of a central authority for allocation of gamma globulin was urged in a resolution adopted at the annual meeting of State and Territorial Health Officers. . . . Russian propagandists are proclaiming on international broadcasts that American surgical journals and other publications demand compulsory sterilization of working women . . . and that millions of American workers' children are blind because of lack of medical attention.

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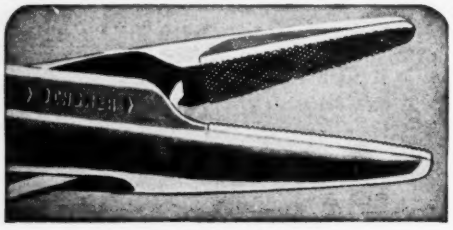

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● Mayo-Hegar	6″	15.75	18.50
● Mayo-Hegar	7″	15.75	18.50
● Mayo-Hegar	8″	17.25	21.75
● Masson	10½″	17.25	21.75
● Heaney "Curved"	8½″	25.75	31.50

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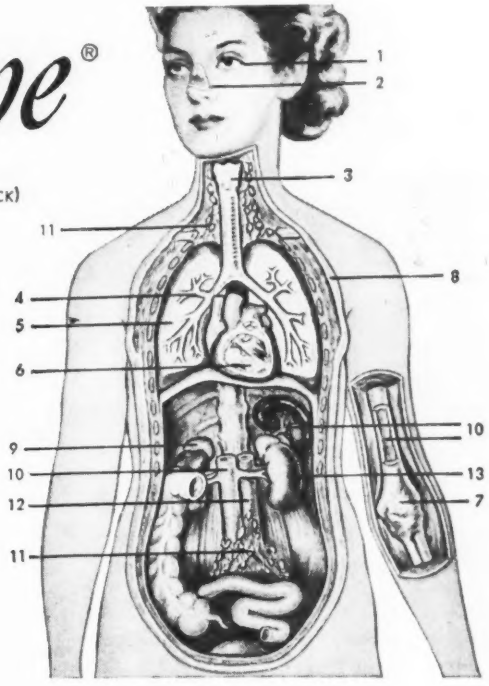

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SYRACUSE, NEW YORK

Student AMA Holds 2nd Annual Meeting

Members of the reference committee on internships, at an informal conference during the convention, are (l. to r.): William E. Cusack, State University of New York College of Medicine at Syracuse; Melvin C. Kadesky, State University of Iowa College of Medicine, Iowa City, chairman; Joseph B. Kohen, Jr., Medical College of Virginia, Richmond.

● The cooperative matching plan for internship appointment, inaugurated in 1951, was approved officially by the house of delegates of the Student American Medical Association at its second annual convention in Chicago recently. The house took action after the association's executive council and the committee on internships had made a study of the plan's first year of operation.

More than 200 persons, representing 50 of the association's 59 chapters, attended the two-day meeting.

Highlight of the program was a talk by Walter C. Alvarez, M.D., editor-in-chief, *Modern Medicine*. An abstract of his paper follows.

Diagnosis with Eyes and Ears Seems to Be Vanishing Art

Walter C. Alvarez, M.D., Chicago—Medicine has been going ahead magnificently in many lines, but the art of diagnosing with the eyes and the ears seems to be a vanishing art. It is important to get the situation or the story behind a disease attack. Often this can best be obtained from a member of the family. The front page and second page and third page of every book on diagnosis should say, "Send for the wife, or the spouse, or the business associate, and talk to him or her. Then, often, you get the story."

To make a good diagnosis, you need to observe and to take a good history. You must ignore the findings which have nothing to do with the case, and you must get an accurate case history. Often this means taking the history yourself or cross-questioning the patient when a previous history has been taken.

To be worth your salt as a diagnostician or a doctor, you have to learn medicine from patients. You can do this by talking with them and cross-questioning them.

You must check every laboratory report. Watch out for the misprints, because even a person who simply copies down or typewrites something can make a mistake.

One day a man walked into my office. Shaking like a leaf, he said he had a sedimentation rate of 112 mm. Anything above 70 may indicate carcinoma. His doctor had told him he had inoperable cancer. The man appeared to be in perfect health, and I found nothing else in the history to justify the diagnosis. Just on a hunch, I made a long-distance call to his doctor and asked him to check his original records, to see whether an error had been made.

When the doctor returned to the phone, he said, "I'm awfully sorry, Alvarez. In typing up the records, the girl copied the figure for blood sugar in the space for sedimentation rate."

This man had suffered unnecessary anguish, because his doctor had placed more trust in the figures in a laboratory report than in his own diagnostic ability.

Don't trust to laboratory reports and x-ray reports. Take a history, look at the patient, and talk to him. Practice cerebrate medicine instead of decerebrate medicine.

Walter C. Alvarez, M.D., Chicago, delivers principal lecture at convention. Topics Photos

NEEDED! HOSPITAL CONTROLLERS

By Leo E. Stevens

● Must an eight billion dollar industry — whose 9,000 unaffiliated components provide a livelihood for over a million employees and spend three and three-quarter billions annually — lose huge sums of money on its day-to-day business operation? In relation to our business economy, this industry should be rated as the nation's sixth largest. The best known and most successful business names in America are members of this industry's directing boards.

In spite of certain similarities, this situation is not intended to describe a government bureau. In fact, I am writing about a group that habitually resists government's paternalistic attempts at absorption and control. I am writing about America's hospitals!

To be sure, few hospitals are ever built or maintained with the idea of making money. Yet, in no American enterprise, hospitals included, is it strategic to ignore fundamentals which have cost an increasingly less sympathetic-American public more than $1,343,000,000 in "contributions" during the past five years.

In this present-day era of labor-saving, cost-reducing business systems, many hospitals do not maintain adequate cost accounting systems. Even fewer have a full-time staff member bearing the title of "controller." As a result, a patient's statement may include hidden charges based on the hospital's last year charity and bad debt experiences. That same statement may ignore the fact that costs may have risen on replacement supplies and equipment actually used.

In this manner, costs for patient care rose $278 million or $1.29 per patient day during 1951 while hospital incomes from all sources increased only $253 million or $1.09 per patient day. The resulting $25 million single year's loss increase had to be added to already monumental "operating losses." Yet, many hospitals have come to consider this a routine problem covered by annual fund-raising drives largely supported by nonpatient members of the community.

The experienced controller would apply specific language and other procedures to such a system. And the fact that the professional controller is truly the missing third man in many patient-hospital relationships becomes even more apparent when a hospital is compared, for example, to a first-class hotel.

While hotels are not hospitals, most hospitals offer hotel-type services. And even though "I can get a room at the Waldorf for that much" is not an unusual patient criticism, many hospitals continue to include laundry, specially prepared room-service meals and other costly services under the heading of "room charges." To compare, the Waldorf would have to make available a host of free personal services and American Plan accommodations at European Plan prices.

Hospitals, unlike hotels, must purchase and maintain technical equipment not used daily in caring for a great majority of their patient-guests. In many cases, by prevailing hospital accounting logic, no part of the maintenance or replacement costs of this necessary diagnostic or life-saving equipment is included in a patient's statement of charges. There is no equivalent procedure in a hotel, but a similar circumstance might result if the Waldorf discovered at year's end that no provision had been made to cover maintenance and replacement costs on their heating plant, lobby furniture and carpet sweepers.

The truth of the matter is that it costs the Waldorf two-thirds less to stay in business than it costs any first-class hospital. Even so, operating with hospital system, that famed hostelry would not likely be long for this world. Hospital accommodations at Waldorf prices are business impossibilities. Good controller counsel would make them hospital impossibilities.

In the San Francisco area, generally considered one of the nation's most costly hospitalization areas, a recent survey of 57 metropolitan hospitals revealed that patients paid an average of $1.11 per patient hour for around-the-clock hospital services. Compare that charge to today's average hourly labor cost, remembering that hospital average 2½ employees for each patient they accommodate, and operating losses are already apparent. To this loss add the costs of laboratory and other technical attentions — not to again mention food and laundry — and the results might be expected to send even the most self-contained business executive to the water cooler, pill in hand.

I have frequently heard that hospitals cannot be operated like business, that the professional and technical people who run hospitals are necessarily and more properly concerned with the institution's humanitarian and social obligations. Perhaps that's as it should be. However, in my twenty years of experience in the hospital field, I have found that hospitals, like businesses, must hire, fire, buy and sell. I have found that hospitals are necessarily businesses — big businesses faced each day with most of the problems common to big businesses.

Coordinating these two responsibilities, and surely such coordination is not an unethical proposal, is the rightful job of a professional controller. This man has too long in too many instances been the missing hospital staff member necessary for a "break-even" operation. And this operational void has too long exploited and restrained America's hospitals.

Hospitals today use the world's most advanced medical professionals, technics and equipment to discharge their principal obligations. Tomorrow they will demand the functional assets of as highly developed professionals, technics and equipment to discharge their practical business obligations. Just that soon will unnecessary yearly losses, annual fund drives and mass public misunderstanding cease to plague the nation's sixth largest industry, a most worthy American enterprise. Just that soon will the cry be issued, "Needed! Hospital Controllers."

LEO E. STEVENS, treasurer and member of the board of American Hospital Supply Corporation, Evanston, Ill., is an active member of Controllers Institute of America. A decade of service as a financial executive of some of America's largest and most active business enterprises preceded Mr. Stevens' current 20 years of experience in the hospital field. Today, he can rightfully be a control commentator whose opinions in the hospital field can be respected.

Reprinted from the October, 1952 issue of The Controller, with permission of the Editors.

Florida Hospital and Nursing Groups Meet

More than 500 delegates attended the joint meeting of the Florida Hospital Association and the Florida State Nurses' Association in Daytona Beach. It was the first time that the two groups had combined their annual meetings. New officers of the hospital association shown at the left are, left to right: president, T. Fletcher Little, director, Halifax Hospital, Daytona Beach; secretary-treasurer, Tracy B. Hare, administrator, Variety Children's Hospital, Miami, and president-elect, John F. Wymer, administrator, Good Samaritan Hospital, West Palm Beach.

New officers of the Florida League for Nursing are, seated, left to right: Mary E. Carnegie, secretary and Mrs. Vivian Duxbury, president, both of Florida State University, and Dora M. Eldredge, Miami, vice president. Standing, are: Mary Luvisi, Jacksonville, past president; Herman M. Hoff, Jacksonville, and Virginia Albaugh, Orlando, both directors.

Chatting between sessions are, left to right: Helen E. Shearston, Miami, executive secretary, Florida State Nurses' Association; Mrs. Mary Mesecher, Davenport, Ia., board member, American Nurses' Association; Mrs. Mary Livingston, Miami, president, State Nurses' Association; Marian W. Sheahan, New York, director, Division of Nursing Services, National League for Nursing, and Shirley McCray, Daytona Beach, chairman, arrangement committee for the convention.

HOSPITAL

Trends

BY LOUIS BLOCK, Dr. P. H.

SPECIAL HOSPITALS*

● Special hospitals are those hospitals limiting their activities to special conditions or groups. In this group, the American Medical Association in its annual Hospital Number includes Maternity, Eye, Ear, Nose and Throat, Children's, Orthopedic, and Isolation. An analysis of what has been happening to these hospitals is pertinent and interesting in light of ever-increasing efforts to make the general hospital more truly general. The effect of this philosophy raises some question on the future growth and development of these special hospitals.

Detailed statistics on what has been occurring in the special hospital picture are available since 1934. Even in the relatively short period, 1934-1951, certain basic trends are evident.

MATERNITY HOSPITALS

Maternity hospitals have *decreased in number from 130 to 90;* a decrease of 31 percent—

Beds have decreased 39 percent from 7,625 to 4,632—

Average size of Maternity Hospitals has dropped from 59 to 51 beds—

Admissions have increased 37 percent from 76,980 to 105,663—

Average number of admissions per bed has increased from 10 to 23—

Average daily census has decreased from 4,647 to 2,952 — and

Percentage of occupancy has increased slightly from 61 to 64 percent.

These trends indicate that there is a decreasing tendency to build maternity hospitals or to add beds to existing Maternity Hospitals. This is indicated by the reduction in number of hospitals, beds, average size and average daily census, and by the fairly constant percentage of occupancy during the period studied. Despite the reduced emphasis on this type of hospital, more patients were admitted into fewer such hospitals having less beds available for such service. The reduced length of stay for maternity patients since 1934 has made this possible.

EYE, EAR, NOSE AND THROAT HOSPITALS

Eye, Ear, Nose and Throat hospitals have shown little change in activity between 1934 and 1951—

Number of hospitals has decreased from 55 to 53—

Beds have decreased from 2,793 to 2,595—

Average size of hospitals has decreased from 51 to 49 beds—

Admissions have increased 10 percent, from 103,720 to 114,516—

Average number of admissions per bed has increased from 37 to 44—

Average daily census has increased from 1,265 to 1,502 — and

Percentage of occupancy has increased from 45 to 58 percent.

In the past 18 years there has been little change in the available facilities, hospitals, and beds, for the institutions classed as Eye, Ear, Nose and Throat Hospitals. The small increase in patients admitted was probably absorbed through the more effective use of the existing facilities as reflected in the almost corresponding increase in percentage of occupancy.

CHILDREN'S HOSPITALS

Children's Hospitals decreased 24 percent in numbers; from 58 to 44—

Beds also decreased five percent, from 5,386 to 5,133—

The decrease in beds was not proportionately as great as the decrease in numbers of hospitals. This fact probably accounts for the increase in average size of such hospitals from 93 to 117 beds—

Admissions increased 54 percent, from 87,571 to 135,043—

Average number of admissions per bed increased from 16 to 26—

Average census decreased slightly, from 3,629 to 3,408, a decrease that is comparable to the slight reduction in beds — and

Percentage of occupancy decreased only slightly, from 67 to 66 percent.

Although Children's Hospitals have decreased in numbers by 24 percent since 1934, the total bed complement has decreased by only five percent. The net result of these decreases was an increase in the average size of such special hospitals by approximately 26 percent. Despite the small decrease in beds in this type of hospital, more patients were admitted in 1951 than in 1934. With a drop in average census of only six percent and a one percent decrease in occupancy it is probable to assume that a reduction in length of stay per patient has enabled more patients to be cared for in fewer such facilities in 1951 than in 1934.

ORTHOPEDIC HOSPITALS

Orthopedic hospitals showed a 19 percent increase in numbers, from 69 to 82—

Beds increased only five percent, from 6,389 to 6,708—

Average size of orthopedic hospitals was reduced from 93 to 82—

Admissions increased 18 percent, from 28,076 to 33,009—

Average number of admissions per bed increased from four to five—

Average daily census increased from 5,003 to 5,209— and

Percentage of company remained fairly constant, showing 78 percent for both 1934 and 1951.

(Continued on page 24)

* *Based on data for the hospitals classified as special hospitals in the May 10, 1952, Hospital Number of The Journal of The American Medical Association.*

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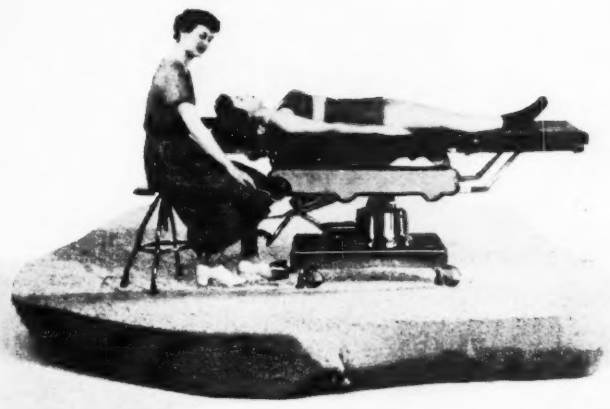

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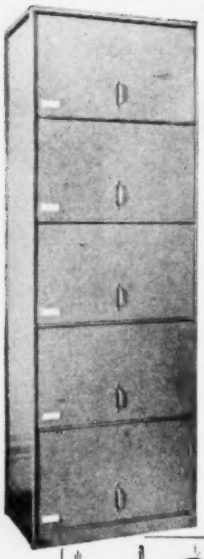

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Although increasing in number, Orthopedic Hospitals are, on the average, getting smaller in size. The increase in admissions of 18 percent was in excess of the percentage increase in beds. With a constant percentage of occupancy the increase in admissions probably reflects a decrease in length of stay.

ISOLATION HOSPITALS

The number of isolation hospitals decreased 44 percent, from 71 to 40—

Beds, on the other hand, increased 28 percent, from 7,430 to 9,516—

Resulting in an increase in the average size of Isolation Hospitals from 105 to 238 beds—

Admissions increased 159 percent, from 38,949 to 101,026—

Average number of admissions per bed increased from five to 11—

Average census increased 74 percent, from 2,934 to 5,097 — and

Percentage of occupancy increased 39 to 54 percent.

Despite the fact that the number of Isolation Hospitals has decreased, total bed complement has increased. Because of this, the average size of such hospitals has grown. In fact, the average size more than doubled between 1934 and 1951. Admissions also more than doubled in that period. This was primarily due to a combination of factors, such as, the increase in beds and increase in percentage of occupancy, assuming no significant variation in demand based upon prevalence of communicable illness requiring such hospitalization.

SUMMARY

Taken as a group, special hospitals are decreasing in numbers. This is specifically true for Maternity, Eye, Ear, Nose and Throat, Children's, and Isolation Hospitals. Orthopedic Hospitals alone showed an increase. The change in bed complement in these special hospitals did not parallel the changes in number of hospitals for each of the special types. Although reductions in beds were reported for Maternity, Eye, Ear, Nose and Throat, and Children's Hospitals, increases in numbers of beds were noted for Orthopedic and Isolation Hospitals. In fact, Maternity Hospitals were the only ones to show an appreciable reduction in beds.

The average size of special hospitals showed somewhat different variations. Decreases were noted for Children's and Isolation Hospitals. The greatest increase in average size occurred in Isolation Hospitals.

Number of admissions increased in all types of Special Hospitals. The greatest increase occurred in Isolation Hospitals, and the smallest in Eye, Ear, Nose and Throat Hospitals. The average number of admissions per bed increased in every instance. This reflected the ability of the hospitals to care for more patients with fewer beds because of the recent trends in the reduction in length of patient stay. This same force, operating in the general hospital field, accounts for part of the increased utilization in general hospitals. Furthermore, in those hospitals classified as Eye, Ear, Nose and Throat, and Isolation, increased utilization as reflected in increased occupancy accounted for a large share of the increased admissions.

Growth in special hospitals has not kept pace with the growth in general hospitals and appears negligible when compared with it. The need for additional services provided in these special hospitals is being increasingly met through special departments in general hospitals.

THE BOOK CORNER

Disorders of the Circulatory System

A Symposium, Edited by Robert L. Craig, M.D., 305 pages, illustrated, pub. by The Macmillan Co., New York, 1952. 1952.

This is, in book form, a symposium presented before the New York Academy of Medicine. The list of contributors includes such outstanding names as Klemperer, Page, Szent-Györgyi, Wylie, Blumgart, Duryee, and Katz.

The subject of circulatory disorders is carried from the physiologic and embryonic beginnings through the phases of pathology and etiology, and finally to the clinical end. Surgical as well as medical diseases are considered.

Kossmann's chapter on the electrocardiographic effects of myocardial and pericardial injury explains many of the findings noted in studying the patient with myocardial damage, and is worthy of study.

The entire book is a valuable addition to the hospital library and that of the practitioner in medicine. Rather than a textbook it is a sound discussion of current methods of detection and treatment of the diseases of the heart, with several chapters devoted to peripheral circulatory disturbances.

Practical Dermatology

By George M. Lewis, M.D., F.A.C.P., 328 pages, 1952, pub. by W. B. Saunders Company, Philadelphia and London.

This is an entirely new book. It is not written for the dermatologist, but is designed for the general practitioner and the student.

The author is outstanding in his field. He is professor of clinical medicine (dermatology) at Cornell, attending dermatologist at the New York Hospital and secretary of the American Board of Dermatology and Syphilology. He is thus well qualified to provide both the scientific and the clinical background to meet the demands of everyday practice.

The author accomplishes his aim in that he employs language which is clearly understood. Where language fails, as is the case frequently in the description of dermatologic lesions, he uses photographic illustrations freely.

Where possible, the various diseases are grouped as to etiologic agent. Where this is not possible, the grouping is according to type of lesion. A quite comprehensive dermatologic formulary constitutes the final chapter of the book.

"Practical Dermatology" is recommended for both the student and the physician in practice.

Problems in Solutions and Dosage

By Stella Goostray, B.S., M.Ed., R.N., 2nd edition, 266 pages, pub. by The Macmillan Company, New York, 1952.

This book is devoted entirely to the mathematics of solutions and dosage. A considerable portion of it is review of arithmetic, with guidance along the lines which will be most useful in the mathematics of solutions and dosage.

The book is intended for the nursing student. It is both a teaching text and a laboratory manual, with review exercises for practically all chapters.

Since the first edition, the author has added and subtracted material, and reorganized the work, thus making the manual more flexible than before. In the sections devoted to exercises, space has been left for the student to work out the problems. Answers to the problems in the review exercises are printed separately from the others, and may be removed by the instructor if desired.

Inasmuch as the mathematics of filling a prescription is a highly responsible factor in determining the outcome in a particular case, it is important that the nurse receive competent and adequate training in this subject. To guide the nursing student in this respect, "Problems in Solutions and Dosage" is an ideal textbook.

Diseases of Metabolism

Edited by Garfield G. Duncan, M.D., 3rd edition, illustrated, 1179 pages, pub. by W. B. Saunders Company, Philadelphia and London.

This book represents the work of twenty distinguished authors, all outstanding authorities in the various branches of endocrinology.

The text is written to assist the practicing physician rather than to delve too deeply into theory. In the words of the editor, the authors have adhered to the aim of bridging the gap between the investigator and the physician treating patients. It is thus a clinical aid, and will assist the clinician in diagnosing and treating his patients.

The chapters are arranged in an orderly manner. Some overlapping of material exists, but the editor deemed it advisable to permit each author to cover his subject as completely as possible in the space allotted. This allows the reader to cover each subject in logical sequence.

The diseases due to disorders of metabolism are covered thoroughly in this work. It is up to the minute as far as both diagnosis and therapy are concerned, containing considerable reference to corticotropin, cortisone, folic acid, and the many other recently available drugs.

For the practitioner of medicine who requires accurate and complete information on the metabolic disturbances, "Diseases of Metabolism" is highly recommended.

Electrocardiography in Practice

By Ashton Graybiel, M.D., Paul D. White, M.D., Louise Wheeler, A.M., and Conger Williams, M.D., 3rd edition, illustrated, 378 pages, pub. by W. B. Saunders Company, Philadelphia and London, 1952.

Since the publication of the previous edition of this book six years ago, electrocardiography has continued its evolutionary development, and the subject has been attaining its majority as a science. New technical and theoretical developments have taken place, all requiring description. The authors have felt, therefore, that this work demanded a complete rewriting. This they have done, together with a thorough revision of the illustrations.

The book adequately accomplishes its chief aim, which is the production of an atlas of electrocardiograms primarily for the practice of medicine. It is very well illustrated, not only with electrocardiograms, but with diagrams where necessary.

There are eight chapters in the book: introduction; methodology; the typical normal electrocardiogram and its variations; disorders of rhythm and conduction; electrocardiographic alterations due to drugs and chemicals; electrocardiographic patterns; etiologic types, and electrocardiograms for practice and interpretation. While it is not intended as a textbook, it should prove considerably helpful to the student as well as the clinician.

HOW TO HANDLE THE SMALL FRY

● More than one nurse has found that keeping a hospitalized child occupied is one of the most effective forms of therapy to speed recovery. In their efforts to keep these tiny tots occupied nurses have devised several novel pastimes for the children in their wards.

Through the ingenuity of their nurse, children in one ward don seven league boots and "travel" to far away places. World maps and photographs taken from atlases and geography books and displayed on a special bulletin board put children in the spirit for travel. At frequent intervals, just following the evening meal, they "tour" a city or a country by way of picture postcards projected on a screen. The postcard file, supplied by parents and friends, is supplemented at times by Walt Disney cartoons cut from magazines by patients able to sit up in bed.

Another nurse was given permission by her hospital to have a number of "honor certificates" printed which were suitable for framing. These certified that the young patient had conducted herself or himself desirably through the period of hospitalization. The certificate was signed by the nurse and by the physician in charge of the ward. Joan and Junior were justifiedly proud to take this certificate with them when they left the hospital.

This same nurse also arranged for a special "Children's Hour" program to be broadcast over the public address system for a half hour each morning and each evening. During this period musical records are selected and dedicated to each patient personally. Interspersed with the music are stories written by the patients, short messages from parents or schoolmates, or items and stories of general interest. This type of entertainment can be arranged even if the hospital lacks a public address system. All that is needed is a microphone, a record player, and a small amplifier which can usually be borrowed from a public-spirited radio shop owner.

Fascination to bed-ridden children derived in attempting to master words in a foreign tongue, prompted one nurse to schedule classes in foreign languages for 15 minutes each day. She pronounces several words in French or Spanish and then gives their meaning in English. These words are written on the blackboard each morning so the children in the ward may study them throughout the day.

The children are also encouraged to make "chalk talks." They may use the blackboard to draw animals, cartoons, or anything they desire. Each day a ward leader, chosen several days in advance, places drawings or games on the blackboard to keep other patients amused. This responsibility of providing amusement for fellow patients helps the children forget their confinement and speeds their recovery. At a week's end, the ward selects the "best ward leader of the week," who receives a toy or an extra portion of dessert as a reward.

A simple, but worthwhile aid is the "memo to the nurse" which parents are asked to prepare before their child is admitted to the hospital. This is a brief statement containing the boy or girl's name, age, favorite sports, special hobbies, types of food the child likes, what he or she reads, and most important, the parent's impression of the child's attitude towards the hospital. Whether the child feels curiosity or resentment, fear or pleasure with regard to his future hospitalization is extremely important.

Armed with this material the nurse can greet the incoming child patient by his first name and can talk intelligently about his hobbies, games, and sports. This report takes only minutes of a parent's time and means more cordial relations between patient and nurse during the hospitalization period.

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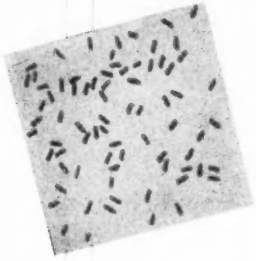

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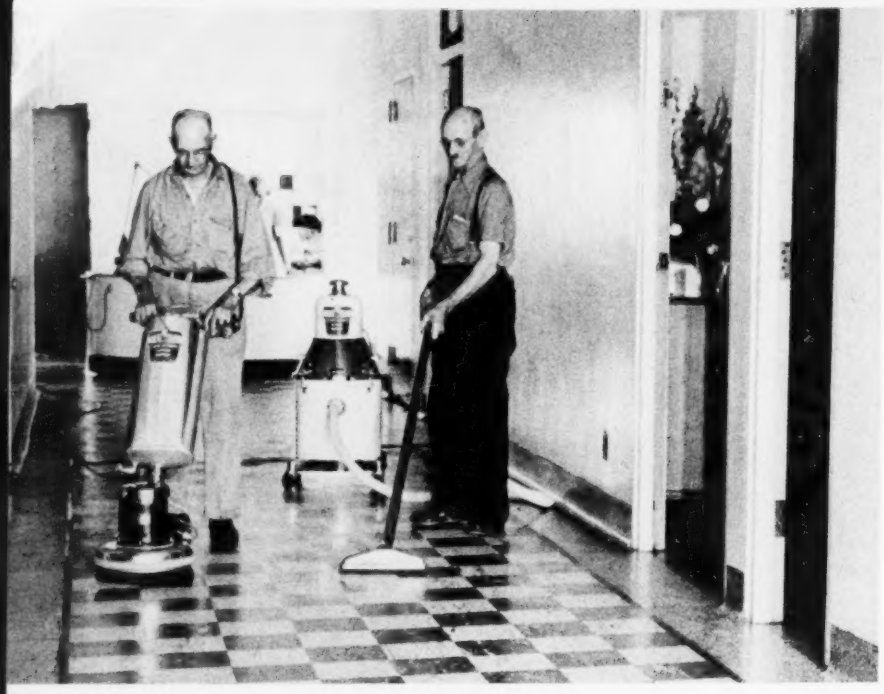

A BIG JOB in the hospital—keeping the floors clean and waxed.

The Use & Care of the Floor Machine

By Dave E. Smalley

● Although fundamental functions of all floor machines are identical, one of these functions being to polish by creating heat through friction and the other to clean by abrasion, there are several methods and a number of designs for obtaining these results. First, floor machines are divided into two general classifications. There is the *concentrated weight* type which operates with all the weight on the brush — the wheels are used only for transport and are raised off the floor while the machine is in operation. Then there is the *divided weight* type in which the wheels help support the weight of the machine during the operation.

BRUSH DESIGNS

Both of these types are divided again into single brush, double brush, and multiple brush designs. All these machines employ flat brushes, usually round, disk style, revolving horizontally. There is still another design which uses a cylindrical brush or steel wool pad which revolves vertically like a drum sander.

Certain exclusive advantages are claimed for each of the different designs. For instance, since the single brush, concentrated weight machine propels itself across the floor and can be swung quickly from side-to-side, it is considered faster in operation. It does, however, call for more skill or practice to prevent it from swinging out of control.

The double brush machine, concentrated weight type, calls for no skill in its operation but must be moved over the floor manually by the operator.

The divided weight machine, either the single or double brush kind, permits the installation of the motor well back on the machine so that the latter can be used under low furniture. It can be operated backward and forward but not side-to-side, and calls for no special skill to run it.

Brushes of the flat type, revolving horizontally, tend to leave circular waves on waxed floors. The softer the brush the less pronounced the waves. Felt or lambswool pads, placed under the brush, further minimize these waves.

In the case of the cylindrical brush which revolves vertically, these circular waves are avoided, but like the divided weight machine this machine must also be operated only backward and forward over the floor.

Floor machines are also classified as "vertical" or "horizontal" types, the terms designating the position of the motor on the machine. In the earlier days of the floor machines their manufacturers were usually obliged to employ stock motors, and since these were designed for uses where the length of the motor made no difference, the motors were tall and often unwieldy when installed vertically. Therefore, several manufacturers used them horizontally with a right angle transmission, usually supplemented with sprockets and chain or pulleys and belt.

HORIZONTAL TYPE HAD BETTER BALANCE

The horizontal type had the advantage of somewhat better balance and it could be used under lower objects than machines fitted with tall, vertical motors. Also, the horizontal machines were quieter in operation, an essential factor for hospital use.

But the vertical application had the advantage of greater power, since the right angle transmission of power on the horizontal type caused a loss of efficiency from 10 percent to 20 percent.

In recent years, however, the floor machine industry has grown to the position where motor manufacturers are glad to make motors especially adapted for their use and short motors are now available. These low motors can be used in vertical position on the machine base and in many instances are no higher than horizontal motors.

The low motor installations are now being made to operate as quietly as the horizontal and with less loss of power. However, the horizontal type is still being made and is said to remain quiet in operation, whereas the vertical application may eventually become noisy. Gears meshing at right angles, as in the case of the horizontal type, more or less automatically adjust themselves to com-

(Continued on page 29)

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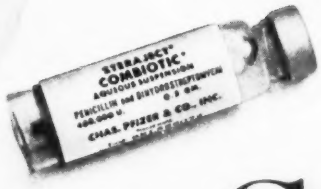

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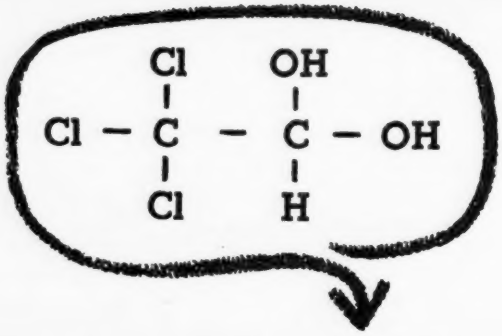

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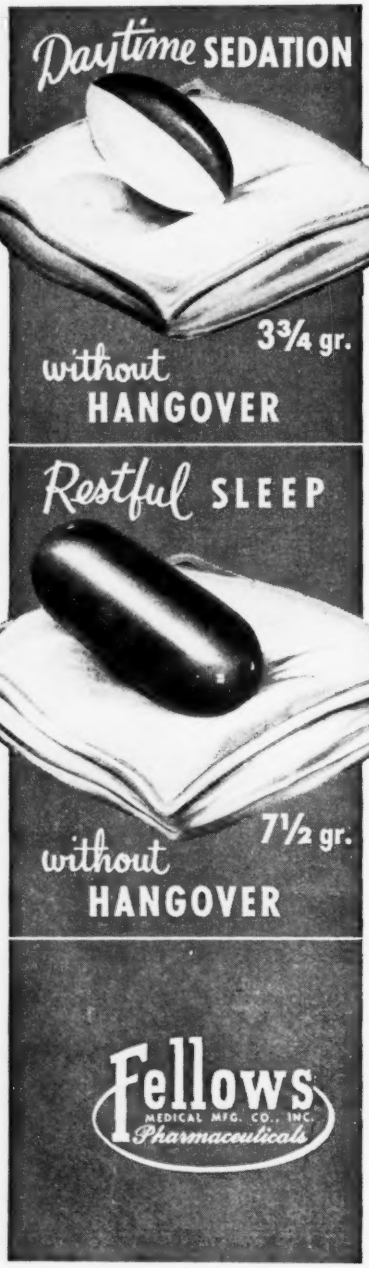

HOSPITAL SIZES:

CAPSULES CHLORAL HYDRATE — Fellows
3¾ gr. (0.25 Gm.) BLUE and WHITE CAPSULES
Bottles of 1000's
7½ gr. (0.5 Gm.) BLUE CAPSULES
Bottles of 500's

3¾ gr. (0.25 Gm.) *BLUE and WHITE* CAPSULES CHLORAL HYDRATE – *Fellows*

Small doses of Chloral Hydrate (3¾ gr. Capsules Fellows) completely fill the great need for a daytime sedative. The patient becomes tranquil and relaxed yet is able to maintain normal activity.

DOSAGE: One 3¾ gr. capsule three times a day after meals.

7½ gr. (0.5 Gm.) *BLUE* CAPSULES CHLORAL HYDRATE – *Fellows*

Restful sleep lasting from five to eight hours. "Chloral Hydrate produces a normal type of sleep, and is rarely followed by hangover."[1] Pulse and respiration are slowed in the same manner as in normal sleep. Reflexes are not abolished, and the patient can be easily and completely aroused . . . awakens refreshed.[2-3-4]

DOSAGE: One to two 7½ gr., or two to four 3¾ gr. capsules at bedtime.

EXCRETION—Rapid and complete, therefore no depressant after-effects.[3-4]

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1. Hyman, H. T.: An Integrated Practice of Medicine (1950)
2. Rehfuss, M. R. et al: A Course in Practical Therapeutics (1948)
3. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics (1941), 22nd printing, 1951.
4. Sollman, T.: A Manual of Pharmacology, 7th ed. (1948) and Useful Drugs, 14th ed. (1947)

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pensate for wear, whereas gears meshing on parallel shafts cannot so adjust themselves to wear.

We have explained these differing features of floor machines since they should be of particular interest to hospital users. In the early days of the floor machine, manufacturers often tested their machines to choose a quiet one for a hospital customer. Sometimes they would try a dozen before they found one which might be acceptable for hospital use.

They need not be so particular now, since most floor machines are relatively quiet in operation, but all manufacturers are still cognizant of the importance of quiet machines for hospital use.

Next to choosing the right floor machine for your hospital is the need for getting the greatest possible service out of the machine. Properly used, a good floor machine will pay for itself in a year or less time, and if properly cared for it should be good for at least 10 years of useful service. A floor machine of the horizontal type has been in continuous use in a certain western hospital for 19 years.

Floor machines primarily designed for buffing are nearly always easily and quickly converted for scrubbing. This is accomplished by using a stiff Palmetto or Bassine scrubbing brush in place of the softer Tampico brush. A solution tank is usually attached to the floor machine handle for feeding the cleaning solution down back of or through the middle of the brush.

At the beginning of this article we said the functions of the floor machine are either to create heat for polishing or abrasion for scrubbing. In either case, for best results, the machine must have weight (for pressure) or speed in order to produce the necessary friction. Small, light machines, therefore, must run faster than larger, heavier ones.

POLISHING FEATURE PREDOMINATES

While scrubbing machines still have a very important place in the maintenance of floors, the polishing function of floor machines predominates, especially in hospitals. Therefore, let us first consider the machine as a polisher. If it is used wisely as such, a saving in floor wax can be effected, mopping can be reduced and scrubbing can sometimes be eliminated.

Too often application of floor wax becomes a matter of routine. Floors are waxed at set intervals instead of when they actually need it. And many times a floor appears to need re-waxing when all that is needed is a good buffing to restore polish of wax still intact but dulled by dust and traffic. The expense of wax and labor of applying it can often be saved by regular buffing.

Then any floor wax must be buffed to remove the mars of traffic. Even the self-polishing waxes must be buffed.

Buffing also loosens adhering dust, cleaning as it polishes, and steel wool pads under the floor machine frequently do a better, quicker cleaning job than wet mopping. Some of the manufacturers of rubber tile and asphalt tile recommend that their floors be maintained with steel wool, the coarser grades (No. 2) when the floors are very dirty and the finer grades (No. "0" or "00") for normal cleaning.

To be sure, there are times when no other cleaning method can supplant water or soap and water and there are hospital people who feel that true sanitation is accomplished only by the wet process. Germicides in the scrub or mop water further insure the sanitation so essential to the hospital.

There are times when floors become overcast from a gradual accumulation of traffic stains or they become yellow or discolored from an excess of floor wax. In such cases a thorough scrubbing is necessary to restore the original beauty of the design and colors and re-create the spic and span effect expected of hospitals.

For such scrubbings best results are obtained by abrasive action with steel wool or an abrasive powder. If the former is used, wet an area about ten feet square with the cleaning solution and scrub. If the abrasive powder is used, wet a like area with plain water, sprinkle the powder on freely and scour. In either case, squeegee off the dirty solution or pick it up with a vacuum cleaner before you proceed to the next area and rinse the floor well at the conclusion of the scrubbing.

It is estimated that one man with a 16-inch floor scrubbing machine (the most popular size) can scrub from 1,200 to 1,500 square feet per hour. With a 16-inch polishing machine one man should polish from 6,000 to 8,000 square feet of unobstructed floor surface in an hour.

Of course the large truck type floor scrubbers, those with vacuum attachments for picking up the dirty solution, can cover the floor much faster than conventional floor scrubbers, but they are adapted only for very large and unobstructed floor areas.

Next to knowing how to select and how to use a floor machine, it is important to know how to care for it.

CARE OF FLOOR MACHINES

One of the most confusing things about maintaining a floor machine is ordering new brushes. Wood back brushes cannot be re-bristled economically. The process of removing the old bristles is more expensive than the cost of a new brush back, so do not send old wooden back brushes to your supplier for re-bristling.

Still more troublesome is size of brushes. Fifteen years ago the Floor Machinery Manufacturers' Association

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CARE OF FLOOR MACHINE continued

agreed that the size of the floor machine would be designated by the diameter of the spread of the brush under the weight of the machine. Therefore, a "16-inch" floor machine means that the spread of the bristles under the weight of the machine shall be 16 inches in diameter.

Although much has been said and written about this rule, buyers of floor machine brushes continue to measure the wooden back of the brush and order accordingly. Therefore, if your brush back measures 14 or 14½ inches in diameter, it is probably considered a 15-inch or a 16-inch brush. But, if you order a 14-inch brush you will get one measuring about 12 inches across the wood back—intended for a 14-inch machine instead of a 16-inch.

Refer to your invoice if you are in doubt about the size of your machine and order your brushes for the size machine the invoice designates.

Care of your machine is important. Keep it clean and do not store it in a damp place. Never park your floor machine with the weight of the machine on the brush. Doing so will mash the bristles down on one side and cause the machine to wobble badly in operation. The best way to preserve the brushes when not in use is to hang them on nails.

However, misshapen brushes can be restored by laying them in about one inch of water for two or three hours, being careful the water does not touch the wood back. Then lay the brushes on their backs, preferably in the sun.

MOTOR DEMANDS CONSIDERATION

Care of the motor demands consideration. Avoid getting moisture in the motor and follow the manufacturer's instructions regarding lubrication. Too much oil, heated in operation, may expand and burst an oil seal, causing the machine to leak oil.

Sometimes the motor is thought to lack power or be defective when either the voltage is too low or the current is being overtaxed.

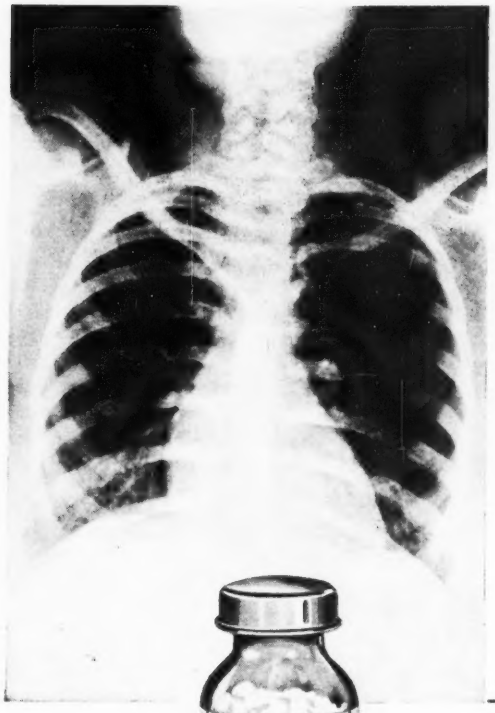
Too many lights or other electrical devices operating simultaneously on the line will reduce the power and the effectiveness of the machine. Often the motor will "growl" and refuse to pick up speed. In such cases, tilting the machine back until the brush can gain momentum will temporarily solve the problem, though it is a condition calling for investigation. If you find the fault is with the machine and not a local condition, notify the manufacturer. If your machine is still under a guarantee, do not tamper with it or let someone else do it, or you may forfeit the guarantee. Also, most manufacturers object to paying the unauthorized repair bill of some local mechanic or electrician.

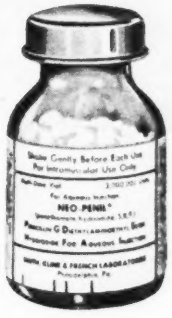
If you find it necessary to return your machine to the factory for repair, see that it is properly crated and marked for identification. In many cases it is only necessary to return the motor.

Remember, any piece of machinery made by any manufacturer can occasionally give trouble, but before you refer the trouble to the manufacturer, be sure the trouble is real. Recently a man drove 300 miles, bringing his floor machine back to the factory because he could not remove the brush. The machine was carried into the receiving room, turned over on its side and a sharp kick administered into the bristles with the heel. The brush fell off.

Don't become alarmed if the motor gets hot. It is built to stand heat—too hot to put your hand on it. If it starts smoking or smelling, there is reason to be concerned.

You have a lot of expensive equipment in your hospital and you know it must be taken good care of. Give your floor machine one-third the attention you do the x-ray machine and it will last for years and give continuous maximum service.





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In response to many requests, chiefly from hospitals, 'Neo-Penil' is now also available in a second size: Multi-Dose vials of 3,000,000 units each. 'Neo-Penil' is the new antibiotic agent—derived from penicillin—which gives higher concentrations in certain body tissues.

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The Inner Voice

An Editorial Written by a Reader

A page designed as an open forum on hospital problems. Contributions are welcomed.

● Recently several of my friends with extensive experience in hospital administration have resigned from their jobs to go into fields where they have had no experience whatsoever. In their new activities the starting salary was substantially above that which they received as hospital administrators. It appears to me that there is certainly something wrong with the pay scale for hospital administrators when a man with years of experience and a specialty can obtain a position in another field in which he has had no experience and start immediately at a higher remuneration. In each instance, the hospital administrator who left was an outstanding person. The continued loss of such people will substantially reduce the quality of over-all hospital administration.

In a large adjacent hospital which has an operating budget of $4,000,000 per year, I was shocked to learn that the administrator was paid less than $8,000 per year. This represents less than one-fifth of one percent of the operating budget. A competent administrator certainly saves much more than this small percentage in each week of operation. Shouldn't the Board of Directors recognize this and do everything within their power to keep competent people?

★ ★ ★

● I am a nurse supervisor of a 200-bed hospital which has recently developed plans for substantial expansion. I understand that the contracts have been let and construction will start shortly. The only way any of us in the hospital were able to keep informed on what was going on was through the daily newspapers. In the hospital field, we are constantly told that the best medium for developing good public relations is through the personnel of a hospital. How can we inform the public when we, ourselves, are not informed?

According to the plans published in the newspapers, it appears that very little thought was given to the size of the nursing unit, or to the location and design of the nursing station. It seems to me that the nurses in general, and the supervisors in particular, should be the first ones to whom the architect would turn in searching for assistance and information in the design of patient areas.

★ ★ ★

● There are a number of old cliches about how one should attempt to curb his temper. I have already counted ten, gone out and walked around the hospital and, perhaps if I write this letter, that too will help. To begin with, I am the administrator of a 100-bed hospital which is located in a town of 9,000 population. Obviously, we do not have an excess of nursing personnel. We try very hard to fit the nurses with their assorted personalities into our organization. Recently, we had a girl with a personality problem which became increasingly difficult to control. She came to me several times with vague complaints about the Directress of Nursing. I tried to control her as best I could. I discovered today, much to my astonishment, that she had paid a visit to the President of the Board of Directors who had listened to her complaints. This morning he came to my office and proceeded to tell me about the discussion he had had with this particular general duty nurse. He proceeded on the assumption that all of her statements were true. I am convinced, after this incident, that I will never again have complete confidence in my Board of Directors, and particularly its President.

Certainly, community hospitals should have as their directors people with enough understanding and administrative competence to recognize that their function is not to accept every bit of gossip, particularly when it emanates from an obviously maladjusted, insecure person.

Review of Law Suits

● A reader asked this question: "We have liability, burglarly, theft, property, storm, fire, collision, indemnity, and various other insurance. Recently one of our buildings was destroyed by fire. The insurance company has refused to pay the loss, because no clause in the insurance policy states that this particular building was covered by the insurance policy. We contend that the insurance company is liable because at the time the application for insurance was signed, I personally instructed the insurance agent that we wanted protection on all of our buildings, and he promised that we would receive a policy giving this protection. I can produce witnesses who will testify that the insurance company's agent promised that our insurance policy would cover all our buildings, no matter where they are located. Can we compel the insurance company to pay the loss?"

According to a higher court, the answer is "no."

First, it is an important and well settled fact, which all higher courts uphold, that an ordinary insurance agent is agent of the insured or hospital corporation, not an agent of the insurance company. This is so although the insurance company pays the agent a salary or commissions on premiums you pay the company. Hence, the company is not at all liable for promises of protection made by the ordinary or "special" insurance agent. All readers should remember this: Irrespective of what an insurance agent tells you and no matter what protectioin you believe your insurance policy affords, you must rely exclusively upon the protection defined by the clauses in the policy. See West vs. Employers Casualty Company, 78 S. W. (2nd) 168.

In Brown vs. ones, 4 Fed. Cas. 404, the higher court held that failure of the policy holder to carefully read his insurance policy does not excuse him, nor result in the insurance company being obligated beyond the insurance specified in the clauses in the policy, although the ordinary or "special" agent of the company verbally promised such broader protection.

CONTRIBUTORY NEGLIGENCE

Another reader asks: "What does the term contributory negligence mean?"

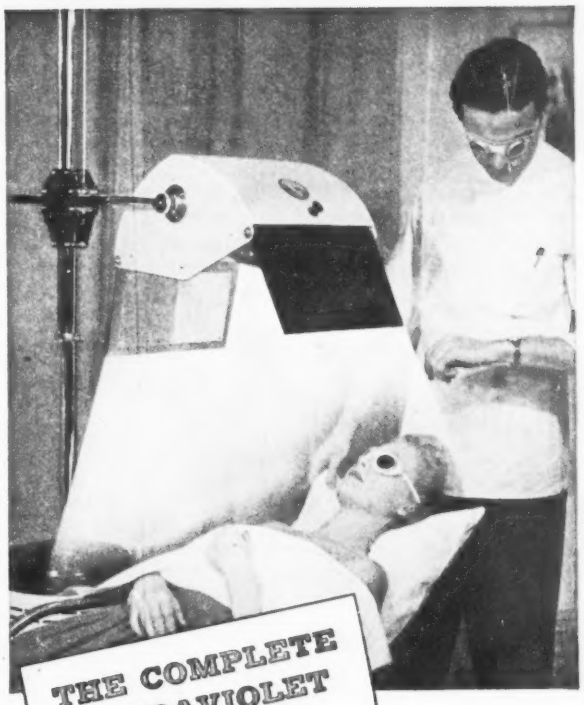
The answer is: The term means that a person who sustains an injury through his own negligence cannot recover damages from a hospital corporation for his sustained injuries.

For example, in Johnson vs. Citizens, 90 N. E. (2d) 145, the testimony showed facts as follows: In the lobby were two elevators side by side. The north one was in regular use for passenger service alone and was manned by an experienced operator. The south elevator was used to carry freight and also for emergency passenger service. Usually it was operated by the janitor, and when it was not in use the door was kept locked. To open the door the janitor used a slender piece of steel which was kept hanging on a radiator in the lobby.

One Johnson obtained the piece of steel, unlocked the door, opened it, stepped into the semi-dark shaft and fell to the bottom. He sued for damages.

The higher court refused to award Johnson any damages, and said:

"This court is unanimously of the opinion that such conduct constitutes negligence. It is dangerous and is a failure to exercise the care of an ordinary prudent person for his own safety. . . . Under these circumstances it must be held that the plaintiff (Johnson) did not exercise ordinary care for his own safety and that his negligence was a proximate cause of his fall and injury."



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TOPICS reports on . . .

The AAAS Meeting Held in St. Louis

Approximately 6,000 scientists attended the 119th annual meeting of the American Association for the Advancement of Science, held in St. Louis from Dec. 26-31. Among outstanding papers presented during the convention were those in the section on medical sciences. Abstracts of some of them are published here.

Planning for Clinical Sciences in the Hospital

E. M. Bluestone, M.D., President, American Association of Hospital Consultants, New York City—We shall know we are approaching the ideal in patient care when the medical scientist and the social scientist work more closely together to protect the interests of the sick person.

Hospital functions have changed greatly. The hospital of today is a complex and intensively used institution. We must adjust our hospital plans to much greater longevity.

Planners must help narrow the gap between principle and practice. The most challenging problem facing layman and physician today is that of prolonged illness, but too many hospital people—trustees and physicians alike—shy away from accepting responsibility in the broader field of medical care. When physicians will cling to their unresolved problems until the very end, the scientific spirit will have come to stay in our hospitals.

Hospitals, if they are to plan soundly, must study rejected patients as well as those admitted. Why are patients rejected? If there is not sufficient room for them, a home care program may be the solution. If the medical staff lacks or loses interest in a difficult, complicated problem, interest may be stimulated by providing financial support for research into that problem, and also by trying to transfer to the chronic diseases some of the glamor now surrounding acute illness.

A hospital which limits the stay of its patients, or which excludes them, whether because of lack of room, loss of interest in prolonged cases, or a desire to keep out infectious or mental disease, is avoiding its responsibilities and wasting its opportunities. The hospital which will be remembered longest and will have the greatest confidence of both medical staff and patients is the one which makes the greatest use of its opportunities in teaching and investigation. Every hospital bed is potentially a teaching and research bed.

FEW HAVE UP-TO-DATE EQUIPMENT

Few hospitals have up-to-date equipment in all specialties, plus the talent to use them to maximum advantage. The failure here is not so much in planning as in the lack of financial support. There is still a tendency, if funds are limited, to put routines ahead of medical education and research.

We cannot afford the loss of a single creative physician to the laboratory. The scientist in medicine deserves a financial reward comparable to that of the physician in private practice. He must not feel insecure, because an insecure physician means an insecure patient.

To convert the medical practitioner into the medical scientist, we must give him the tools with which to work and the means of using them to best advantage.

When a hospital accepts the responsibility of a home care program, planners must allow for more service space within the hospital, too, since more beds are being served. There must be provision for portable diagnostic and therapeutic equipment, wherever practicable.

Hospital therapy is handicapped by the impersonal atmosphere which prevails in hospital wards. Planners must consider the need for more individual care. It will cost more in money and energy, but the increased expense will be offset by the low cost of the home care program.

The hospital must have laboratory facilities on the premises, unless it has a working arrangement with a laboratory outside the hospital. Every hospital of medium size and over needs a small pharmacology laboratory, a general physiology laboratory, and a neurophysiology laboratory.

Surgery is still based too much on a knowledge of anatomy instead of physiology. If the ideal is to reduce the need for surgery by developing better preventive medical measures, the physiology laboratory certainly can be of great assistance.

Assimilation of Food—Vitamins and Minerals

C. A. Elvehjem, Department of Biochemistry, University of Wisconsin, Madison—The importance of soil in assuring an adequate diet is well known. In 1949, Sir John Russell estimated that the prewar British diet required 1.5 acres of food-producing land per head. He suggested that a vegetarian diet with milk requires 0.75 of an acre and a vegetarian diet without milk requires 0.5 acre, and that the average area expected to be available for food production in 2000 A.D. would be about one acre per head. It has been estimated that the present level of nutrition in the United States requires about 3.5 acres of agricultural land per person.

At present little difficulty should be encountered in supplying the vitamin and mineral requirements of human beings even if the available land were reduced below one acre per head. With synthetic vitamins, vitamin concentrates, and mineral salts almost any diet can be rendered complete in these respects. This was impossible a few years ago, but as a result of the productive research during the past 25 years, we have learned most of the vitamin and mineral requirements of cytoplasm.

Synthetic ability of cytoplasm is evident when we realize the rapidity with which living cells can build inorganic iron into the complex molecules such as hemoglobin and cytochrome.

Most mineral elements can be supplied as simple salts and the animal body is able to build these salts into the structures necessary for the cytoplasm.

When we pass on to the vitamins, we find that the plant is much more important as an intermediate between the soil and animal organisms. However, even here we cannot make generalizations since there are numerous interesting exceptions. The best known exception is in the case of vitamin D. No plant product contains sufficient vitamin D to supply the need of animals. Down through the centuries animals have received their supply of vitamin D either through the action of sunlight or ultraviolet light directly on the surface of the animal or through the consumption of other animal products containing vitamin D.

Nutrients can now be put together in a fairly satisfactory ratio in order to produce what we may call optimum health.

Similarly, clinical workers have emphasized specific

Representatives of the four organizations having a voice in U. S. pharmacopoeia were assembled for the first time during the AAAS convention. The organizations are: the U. S. Pharmacopoeia, the National Formulary, the New and Nonofficial Remedies, and the Accepted Dental Remedies.

Participating in a convention symposium on their role in developing and maintaining sound drug therapy trends and standards were (l. to r.): Linwood C. Tice, dean, Philadelphia College of Pharmacy and Science; Robert T. Stormont, M.D., secretary, AMA Council on Pharmacy and Chemistry, Chicago; Justin L. Powers, chairman, Committee on the National Formulary, Washington, D.C.; Lloyd C. Miller, director of revision, *U. S. Pharmacopoeia*, New York City; Louis C. Zopf, dean, School of Pharmacy, State University of Iowa, Iowa City; and J. Roy Doty, Ph.D., secretary, Council on Dental Therapeutics, American Dental Association, Chicago. At right is George F. Archambault, U. S. Public Health Service, Washington, D.C., chairman, subsection on pharmacy.

symptoms in the diagnosis of nutritional deficiencies. Perhaps too great emphasis has been placed upon a specific syndrome since the condition may vary depending upon the severity of the deficiency and the rate at which the deficiency develops. The symptoms vary considerably from species to species.

Our purpose today is not to cure deficiency diseases after they develop. Our function is to prevent the development of any abnormal changes in the metabolism of the cells in the human body. Today we can obtain phenomenal growth in young animals placed on so-called synthetic rations. In fact, we can obtain one gm. growth in an animal from two gm. of ration. Even greater efficiency can be obtained by adding certain antibiotics to the ration.

A relatively new group of compounds which are structurally similar to vitamins but which cannot produce active enzymes are the anti-vitamins. The anti-vitamins of folic acid, have a limited application in the treatment of leukemia.

Importance of Carbohydrates and Fat

H. J. Deuel, Jr., University of Southern California, Los Angeles—Contrary to general opinion, both carbohydrates and fats have an important place together in all diets. Each foodstuff has its own function to perform. When immediate energy is needed, carbohydrates work best. But fats are a more satisfying food.

Good hot weather diets should include large proportions of fat at the expense of carbohydrates. In the tropics, where extra heating of the body by eating is undesirable, protein diets containing a high proportion of fat are to be preferred to ones containing largely carbohydrates. Fats will reduct the extra waste heat which must be liberated from the body.

That the sexes react differently to these foodstuffs is one of the most interesting facts to result from research at the University of Southern California. Men store larger amounts of carbohydrates in their bodies. Women have more fat in their tissues. This is important if men and women go without food in a seven-day fast. Women will have five times as much acidosis as men. The women will become ill with nausea, vomiting and shortness of breath. The men in general will be able to carry on their usual tasks without any serious difficulties. In both sexes, this condition can be prevented if just the amount of sugar in one glass of orange juice is drunk each day.

Blood Pressure and Race

Victor E. Levine, M.D., Creighton University School of Medicine, Omaha, Neb.—Various clinical investigators place the incidence of hypertension in our adult population in the incidence of hypertension in our adult population at 20 to 40 percent. It has been estimated that two-thirds of those who die in this country of cerebral hemorrhage and three-fourths of those who suffer from coronary disease have high blood pressure. According to our vital statistics of 1949, hypertension took the lives of 83,000. In many of the 207,223 deaths reported due to coronary disease and 102,443 deaths reported due to cerebral hemorrhage, hypertension may have been a major contributory cause. Europeans also have a high incidence of hypertension.

While high blood pressure is common among the white populations of Europe and America, it is indeed very rare among the Asiatic population groups. It is also rare among native Africans, Australian aborigines, American Indians, and Eskimos. As a matter of fact, a study of the systolic and diastolic blood pressure of these peoples indicate that they have a lower blood pressure than that of white population groups.

I have made a study of the blood pressure of Eskimos and also found the prevalence of lower blood pressure in comparison to that of whites. I found a mean systolic

Speakers on program for subsection on pharmacy included (l. to r.): Charles C. Rabe, Jr., St. Louis College of Pharmacy and Allied Sciences; Don E. Francke, University of Michigan Hospital Pharmacy, Ann Arbor, Mich.; Grover C. Bowles, Strong Memorial Hospital, Rochester, N. Y., president, American Society of Hospital Pharmacists; Linwood C. Tice, dean, Philadelphia College of Pharmacy and Science; George F. Archambault, U. S. Public Health Service, Washington, D. C., and C. Lee Huyck, St. Louis College of Pharmacy and Allied Sciences.

of 109 and a mean diastolic of 70. Blood pressure did not rise with age as it does among white population groups. That blood pressure does not rise with age has also been noted by other investigators among Chinese, native Africans, and American Indians.

The factors involved in blood pressure apparently are not race, but such items as diet, disposition, and temperament, coupled with tempo of the life led by the European and particularly by the American, and least in importance, climate.

Amino Acid and Peptide in Nutrition

Sidney W. Fox, Iowa State College, Ames—Isolation of amino acids from hydrolysates for direct use, as in nutritional experiments, has the advantage of providing the preferred configurational form of each of the amino acids. A principal disadvantage, however, is one of uncertainty of contamination by other amino acids from the hydrolysate. As synthesis and resolution become jointly more economical, they are more often the method of choice in preparing diets. Nutritional experiments may be seen to be constructed with synthetic amino acids with increasing frequency.

Tryptophan, lysine, and methionine have accordingly received special attention from synthesists. Whatever the complex interplay of economic and chemical factors, the nutritionist cheerfully recognizes that he is able to buy a pound of dl-methionine at a price which not many years ago brought but a few grams.

The most widely used type of method of amino acid assay has been that of the microbiological. For most of a decade, amino acid assay has been assisting the corn breeders in their effort to improve the nutritional quality of corn protein by artificial selection.

Although to a large degree the nutritional quality of a protein is expressible in terms of its amino acid composition, it is recognized that other factors are also important, and that among these are factors stemming from special features of peptide linkages. The fractionation of peptides may be of some value here, and methods analogous to those for amino acids can be put to work.

At present, knowledge of the chemical course of digestion is being accumulated in this field as the result of development of quantitative methods of positional residue analysis of peptides. Some information on the proteolytic release of aminoid residues has been obtained.

Three Carbohydrate Tolerance Tests

Hans B. Molholm, M.D., Washington University School of Medicine, St. Louis—By means of a flicker photometer, visual sensitivity to different colors was measured in 25 adult male subjects on whom carbohydrate tolerance tests were done. By comparing the tolerance data obtained from the ten subjects having the lowest visual sensitivities to red with those obtained from the fifteen subjects having the highest sensitivities, a highly significant relation was found between visual sensitivity to red and what happened to the blood sugar in the tolerance tests.

The finding of this relationship has led to the finding of several highly significant relationships among the different sets of tolerance data themselves. Probably the most important of these relationships is that connected with the fact that in the intravenous glucose tolerance test used in the study of blood sugar continues to rise for three to five minutes after the completion of the injection. Apparently this intriguing phenomenon has aroused little or no curiosity because no one has made a serious attempt to account for it.

A direct relation has been found between the levels to which the blood sugar rose after the injection and the rates at which it then decreased. The higher the blood sugar first rose, the more rapidly it then decreased.

This finding suggests that what happens to the blood sugar in the first part of this particular test is an ambivalent allegory of what is going to happen to it during the later part of the test. The blood-sugar-decreasing mechanisms that remove glucose from the blood stream during the later part of the test are made to act as blood-sugar-increasing mechanisms during the first part. By thus being made to act as blood-sugar-increasing mechanisms these blood-sugar-decreasing mechanisms are adjusted so that they are better glucose-removing, or blood-sugar-decreasing, mechanisms.

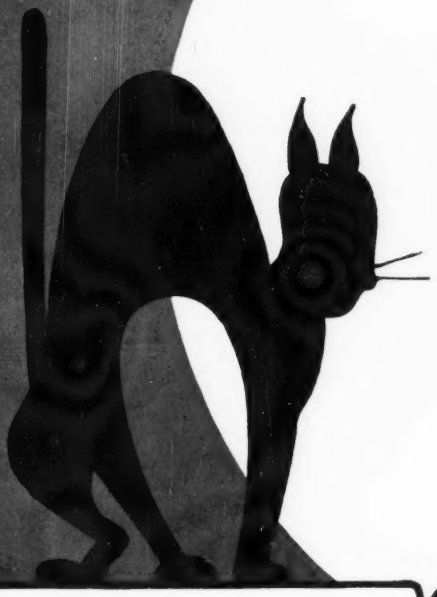
But in order to have all this happen, a pancreas is needed that has the capacity to increase the rate at which it is secreting insulin. If, however, the pancreas does not have such a capacity, the blood-sugar-decreasing mechanisms are unable to stop acting as blood-sugar-increasing mechanisms whenever an increase in blood sugar makes them begin acting so, and then the result is diabetes mellitus.

Present Status of Cancer Chemotherapy

Louis H. Goodson, M.D., Midwest Research Institute, Kansas City, Mo.—Today only a few chemical agents have a proven place in the therapy of cancer, and these are effective in the management of only a small number of human tumors. When used either alone or in combination with surgery and radiation therapy they have not materially reduced the cancer mortality rate. The two main reasons for this are that many tumors such as melanomas which do not respond favorably at first later become resistant to the drugs and the tumors resume their uncontrolled growth.

The so-called anti-cancer agents which are currently receiving some clinical application in the treatment of the less resistant types of tumors such as chronic leukemia and lymphoma may be classified on the basis of their mode of action. The radiomimetic agents are believed to react irreversibly with the protein within the cells and thereby interfere with the process of cell division. The hormones are believed to interfere with the growth of tumors by changing their environment. For example, cancer of the prostate is stimulated by androgens. Administration of estrogens represses the production of androgens and temporarily inhibits the growth of the tumor.

HOW... to get the most out of your *Catgut* SUTURES

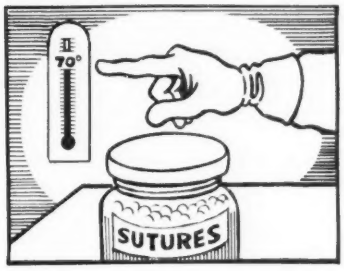


DON'T HOARD OLD STOCK

1. Use old stock first. Properly stored surgical gut does not deteriorate because of age.

Improvements in manufacturing processes and changes in surgeons' technics can make old materials obsolete. You can avoid this.

WATCH TEMPERATURES



2. Keep sutures stored at normal room temperature.

Prolonged storage at temperatures in excess of 100° F causes deterioration of gut. (Cooking tenderizes meat!)

WATCH LABELS

3. Never autoclave or boil non-boilable gut sutures. Labels clearly identify boilable or non-boilable materials.

Heated strands can be recognized by tightened coils of gut or badly contracted reels. Such tubes must be discarded. Excessive heat destroys protein.

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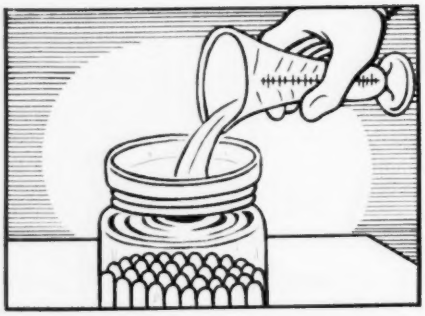
TURN PAGE

CARE IN HANDLING CATGUT SUTURE

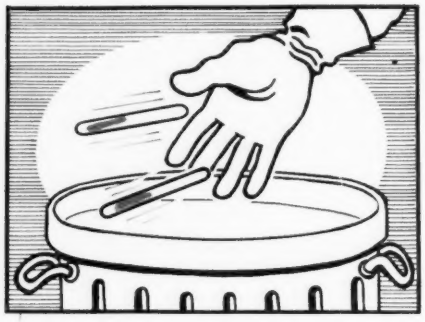
SUBMERGE TUBES



4. Keep all tubes covered with storage fluid even though Ethicon storage fluid will sterilize in the vapor state, given sufficient time.

Airborne organisms may settle on exposed ends of tubes. If used too soon, tubes will not be sterile.

DISCARD "LEAKERS"



5. Discard tubes which show purple or other color in the liquid or on label **inside** the tube. (The color is a warning signal of presence of storage fluid admitted by cracks in tube)

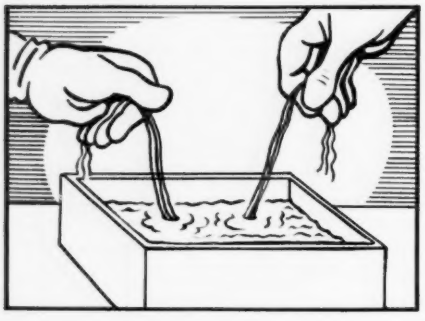
Water and formaldehyde of storage fluid inside tubes reduce suture strength by as much as 30%.

DON'T CUT S

6. When opening that the suture is r on the glass tube center-scored for Strands may be sh

The sharp edges the suture. A slig danger spot.

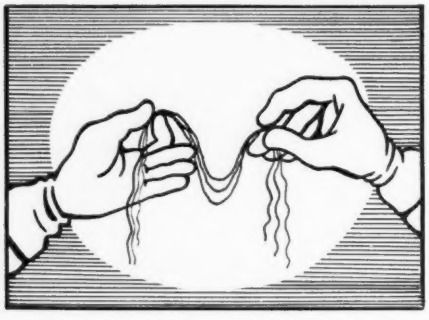
DON'T SOAK



9. Avoid soaking of strand.

Excessive exposure to water makes the strand limp and soft. It swells the gut and reduces tensile strength by as much as 30%.

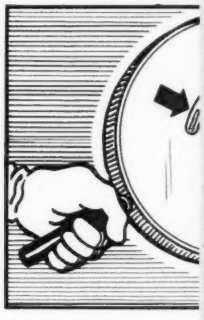
AVOID RUBBING



10. Avoid excessive handling of gut sutures (rubbing, wetting, etc.)

Friction between rubber gloves and surgical gut may result in fraying.

INSPECT NEE



11. Be sure that rough and sharp.

Defective needl a suture and ca fraying in use.

© Ethicon Suture Laboratories Incorporated, 1952

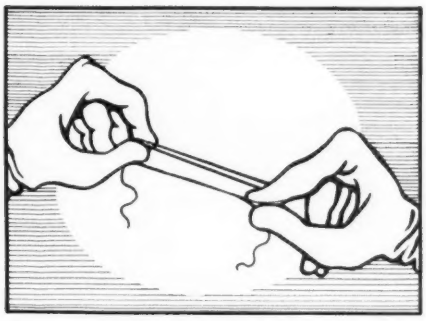
S WILL SAVE YOUR HOSPITAL MONEY

TURES

he tube, be sure
at the score mark
Ethicon tubes are
our convenience.
ken to either end)

the glass will cut
cut is a potential

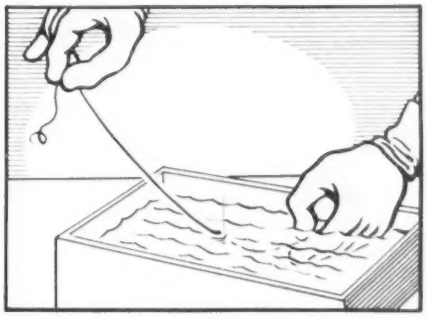
STRAIGHTEN CAREFULLY



7. Straighten the strand with a steady even pull—just enough to remove reel bends. (For standard tubes—an excellent procedure is to double the strand before stretching—better control of tension—better aseptic technic)

Jerks and tugs can weaken the suture. Weak spots are trouble spots.

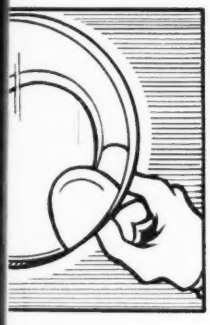
KEEP MOIST



8. If strands are not used immediately after opening tubes, store strands in a dry sterile towel and then dip individual suture momentarily in sterile water or saline of room temperature.

Prolonged storage in a moist towel will have the same harmful effects as soaking. Prolonged storage in a dry towel may reduce pliability—this is restored by a momentary dip in sterile water.

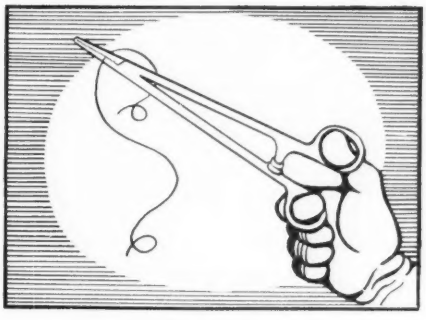
LES



edle eyes are not

eyes will damage
breakage and/or

DON'T CRUSH GUT



12. Handle suture with instruments only where absolutely required.

Instruments may crush suture material, thus causing weak spots.

RE-STERILIZE LEFTOVERS

13. Store unused tubes at end of operation in an intermediate container with sterilizing fluid overnight before returning to regular suture supply.

Organisms from previous operation may contaminate the next case.

OTHER FREE EDUCATIONAL MATERIAL SUITABLE FOR USE IN SCHOOLS OF NURSING

MOTION PICTURE

Sutures Since Lister

A forty-four minute film showing the operating room of Lister's day and many of the dramatic changes in O. R. technics which have occurred since that time. Pictures the making of catgut sutures, from sheep intestine to sterile tube. Black and white, 16 mm. with sound.

LITERATURE FOR NURSES

Ethicon Manual of Surgical Knots

Pictures methods of tieing standard surgical knots and gives valuable information about operating room procedures.

Ethicon Handbook of Sutures

History and description of all suture materials now in use. Gives complete information on how to prepare and handle suture materials.

LITERATURE FOR OPERATING ROOM SUPERVISORS

Ethicon Manual of Operative Procedures

Pages of drawings illustrating steps in most standard surgical operations.

Surgical Experience with Finer Size Sutures

Profusely illustrated brochure giving the scientific background for the modern preference for finer gauged sutures.

Hospital Topics Year Book for 1952

Reprint collection of the past year's most valuable articles from the Ethicon sponsored O. R. Section of Hospital Topics Magazine.

For additional free copies of "How to get the most out of your Catgut Sutures," write

ETHICON SUTURE LABORATORIES INCORPORATED

NEW BRUNSWICK, NEW JERSEY

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PRINTED IN U.S.A.

Hospital Topics ..... Goes Calling

. . . on

People with a Problem
Resurrection Hospital
Chicago

By Marie Jett
Associate Editor

● If your hospital were 63 percent completed and you needed $500,000 to finish the job, what would you do?

Resurrection Hospital on Chicago's Northwest side had to solve that problem last fall. Total anticipated expenditures for construction and equipment came to $4,000,000, even though the Sisters of the Resurrection had donated the $250,000 hospital site. Total anticipated resources, including a $400,000 non-interest-bearing loan from the sisters' savings over a 52-year period, were only $3,500,000. The remaining $50,000 was needed to guarantee completion of the hospital by June and occupancy by September, 1953.

Need for the institution is admittedly great, for there is no hospital in an area populated by 281,709 persons.

The Rt. Rev. Msgr. John W. Barrett, archdiocesan director of hospitals, and members of the order were all determined that the hospital would be finished and that it would have the finest equipment and facilities available for its patients.

First step toward solution of the problem was the employment of a professional fund-raising counsel, whose job was not only to obtain the large contributions which make up the bulk of the financial support in such a drive, but also to coordinate the work of volunteers who were eager to help.

The new campaign had one strong disadvantage: the project had extended over a lengthy period already. There had been one organized campaign which had resulted in the collection of only $200,000 of the $1,000,000 goal. Plans for construction were announced in 1946, and the first fund-raising campaign began at the end of 1948. The need for hospital beds increased as the community's population mounted, and original estimates of construction and equipment costs went up along with other prices in the inflationary period following World War II. What had started

(Continued on next page)

Effective campaign brochure cover asks readers to choose between uncompleted hospital (l.) — going to seed — or completed hospital (r.) — serving the community.

(Continued from page 37)

out to be a 100-bed hospital became a 190-bed, 44-bassinet, $4,000,000 hospital.

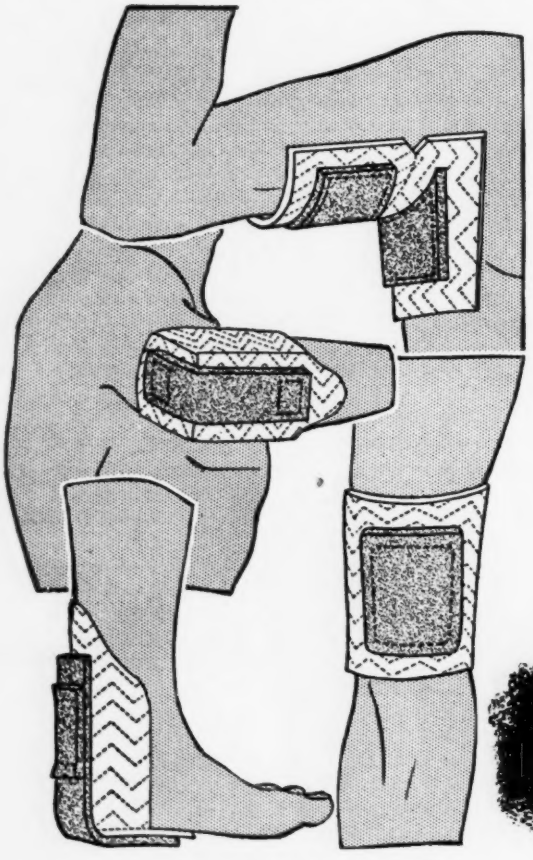
The building campaign had been going on so long that it was quite possible the community had been "campaigned to death." There had been an all-star benefit featuring show people, a benefit football game, raffles, dances, and numerous parties to raise money for the building fund. Public support had been good, but the amounts raised at such functions, as the professional counsel pointed out, did not begin to compensate for the vast amount of time spent on them by workers.

Moreover, because requests for contributions had been made so frequently, the effect undoubtedly was to encourage smaller contributions. The man who could have afforded a $500 contribution, for example, perhaps was asked for $50. Lack of professional advice caused volunteer fund-raisers to "set their sights too low."

Another handicap—one that is perhaps typical of big-city neighborhoods—was the lack of community spirit. Certainly, Monsignor Barrett pointed out, there is much less of a feeling of unity in a city section populated by 282,000 persons than there is in a small city of the same total population. It is more difficult, also, for the fund-raiser, in organizing his campaign, to estimate the amount each potential contributor might give, while in smaller cities it is easier to ascertain the approximate financial status of an individual.

One point definitely in Resurrection's favor, however, said Monsignor Barrett, was its early formation of volunteer organizations—the Men's Foundation and a women's auxiliary. "Their loyalty and efforts kept the drive going, and from their groups may well come interested, informed hospital board members," he declared. Now, working in cooperation with the professional fund-raising counsel, these persons are channeling their energy to greater advantage.

Monsignor Barrett checks progress of construction, which was 75 percent completed at the time this picture was taken.



PLASTER CAST PADDING

Saves Orthopedist's Time
Gives Greater Patient Comfort

These pre-cut and pre-shaped pads let the orthopedist fashion his cast immediately around them. There is no time wasted shaping loose cotton. The pads, of soft quilted material, are tailored and sewn to exactly fit the joint. They help the fracture surgeon shape a perfect cast that is far more comfortable than one made with loose fibrous padding.

For a Complete Description
Call or Write

De Puy
MANUFACTURING COMPANY, INC.
WARSAW, INDIANA

First, the counsel had to focus public attention on the problem. To do this, the campaign steering committee made a critical situation look urgent. It was decided to let it appear as though construction might be halted unless the hospital could give definite assurance that it could raise the remaining $500,000.

Actually, the situation was—and is—urgent. If fund-raising efforts fail, church authorities probably will provide a loan to insure completion of the project. But the loan, like a bank loan which might be obtained by a non-religious hospital in a similar situation, would have to be repaid with interest. The hospital would have to charge higher rates to meet its expenses and keep up its payments, and the people least able to afford high costs would be the hardest hit.

To put across the seriousness of the situation to the public, campaign leaders persuaded the mayor of Chicago to give official recognition to it. A statement was issued from the mayor's office, calling attention to the great need for a hospital in the area.

Shortly after the mayor called upon Chicago citizens to support the hospital drive, statements were obtained from five prominent civic and business leaders of the region, pledging their support, and requesting the public to join them in giving financial backing. The hospital had succeeded in putting itself in the position of having the public (through prominent citizens) ask that the hospital be completed.

To help create this public demand for hospital completion, campaign directors sought help from newspapers and radio stations, particularly the community newspapers, which are sometimes better read by the people in the regions they cover than are the big metropolitan dailies.

Because newspaper publishers and radio personnel knew all the facts, they gave their full cooperation. There was no attempt to withhold information from them, or to be anything but completely aboveboard.

In canvassing the community and building up community pride and unity, auxiliary workers, especially women, are proving helpful. A new group organized to make use of enthusiastic volunteer workers is the "Mrs. and Mr." organization. Wives are asked to approach the tradespeople with whom they deal all the time—the grocer, the butcher, the baker, the merchant, the milkman, the proprietor of the cleaning shop. Husbands are asked to talk to the tradesmen they are most likely to see—the banker, the filling-station operator, the bowling-alley owner, the liquor store owner.

If a woman discovers that someone on her list may be a "big donor," she is urged by the campaign committee to call in her husband to assist her in her sales talk—since men are considered better qualified to talk "big money" than women are. With this "team approach," campaigners hope to get good results from the efforts of their volunteer workers.

The idea of establishing memorial rooms is proving popular in this campaign, as it has been in others. One of the promotion pamphlets features a floor plan of the hospital, with every room and laboratory marked, so that persons interested in establishing memorials may select specific rooms if they so desire.

After a time-consuming but essential period of campaign organization, the drive is now in full swing. In June the counsel and the campaign committee will know whether they have turned failure into complete success. Results so far are encouraging.

MATEX 6
MATEX 6½
MATEX 7
MATEX 7½
MATEX 8
MATEX 8½
MATEX 9
SORT SIZES QUICKLY THE MATEX KWIKSORT WAY
Quick-as-a-wink inexperienced help can sort and "pair up" Kwiksort size marked surgeons' gloves. Big, bold figures plus a distinctive design identify each of the seven popular glove sizes. Even when gloves are turned inside-out or with cuffs turned back, this size identification can be plainly seen. Kwiksort is an integral and therefore permanent part of the glove, it can't wash-off, rub-off, fade-off. Autoclaving will not affect it.
To simplify sorting and avoid glove mis-mating, order Matex (white) or Massillon Latex (brown) surgeons' gloves with Kwiksort size identification.
Kwiksort
THE MASSILLON RUBBER COMPANY
MASSILLON, OHIO

BUYER'S GUIDE

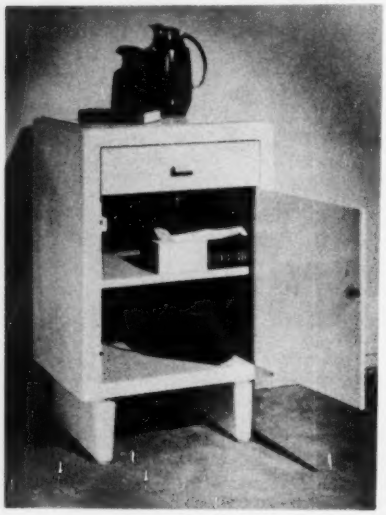
. . . for full information on any product in this section

use the handy reply card facing page 44

1179. Nurses' Call Button Holder—novel device slips on standard bed rails in any convenient position. Prevents damage to buttons and linens. Keeps cord neatly off the bed. Holds button in upright position for patients' convenience. Needs no tools for installation and need not be removed for change of linen. Kad-Ette Products.

1178. Jayne Bryant Safety Check Blanket for restraining confused, excitable, or violent patients, provides absolute security, yet permits maximum comfort and freedom of movement. Made of sanforized canvas, launders easily. Ties securely to the movable frame of a hospital bed by ropes which pass through grommets spaced at eight-inch intervals. A 75-inch zipper opens down the center for quick and easy access to patient. An additional zipper opening 30 inches long on either side of center zipper gives further accessibility. Two more openings permit patient's arms to be free when desirable. All zippers are strain-resistant and can be locked. Jayne Bryant Safety Check Blanket.

1180. Long-lasting sharpness and outstanding strength are special features of the new complete line of carbon-plated steel surgical needles. Needles are packed in a transparent, unbreakable plastic vial, secured with a "tamperproof" seal which makes the container moisture-proof, dustproof, and rustproof. Needles remain visible at all times. The new line of needles supplements Ohio Chemical's regular line of stainless steel needles. Ohio Chemical & Surgical Equipment Co.

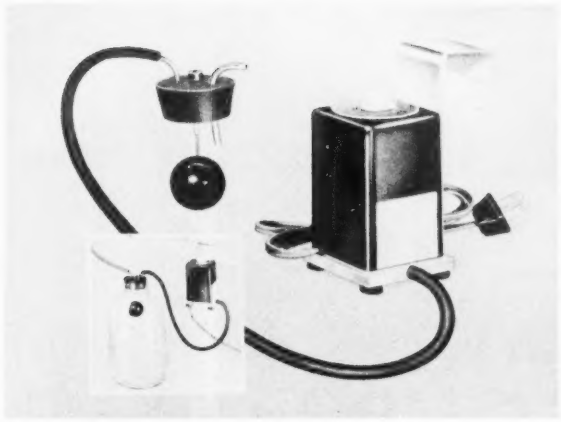


1151. Metal Bedside cabinet is small in overall dimensions in order to meet the need of crowded hospitals where space is at a premium. Available with or without a Formica top. Equipped with one drawer and one shelf which is removable and adjustable. Royal Metal Mfg. Co.

1181. Beam-Matic Folding Service Tray makes serving easier. Tray is loaded in the kitchen and brought to the room with legs folded. When placed before patient, a slight finger tip pressure opens the legs automatically. Front of the tray is open to permit the patient to rest his arms on a flat surface without upsetting the tray. A small ridge on the front prevents the dishes from sliding off. Made of aluminum with stainless steel parts. May be machine washed or sterilized. Aluminum is anodized for protection against rust, wear, and chemical attack. Lightweight, weighing only 4 lbs., yet, according to manufacturer, it will not collapse. Beam Metal Specialties.

1185. New line of Fresh'nd-Aire Conditioners feature a single All-Season Weather Control Dial. By changing the position of the Control Dial the unit performs each of the following functions: Filters and heats the air; filters and cools the air; filters and dehumidifies the air; becomes a low-speed or high-speed ventilator to provide filtered, fresh air; has a special slumber speed for economical and comfortable slow-speed night cooling. Cory Corp.

1140. New type of defibrillator eliminates shock hazard to the surgeon and is simple to operate. Adjustable current intensity and automatic cycling prevent overtreatment through personal error. Simple in design, requires a minimum of previous operator instruction. Incorporates a simple one step pre-test operation that guarantees a fully effective treatment. Coleman Instrument Co.



1182. A new vacuum pump has all the power necessary for continuous mild drainage and aspiration, yet occupies only 2½ inches of space. Unit operates on electromagnetic principle; has no moving parts. Dial control makes possible variable vacuum from two to 15 inches; air displacement up to 600 cubic centimeters per minute. Supplied complete with special float which fits ½ or 1 gallon Mason type jars. The unit is sealed in a black case mounted on a machined aluminum base. An aluminum bracket is supplied to attach pump unit to bed rail. A. S. Aloe Co.

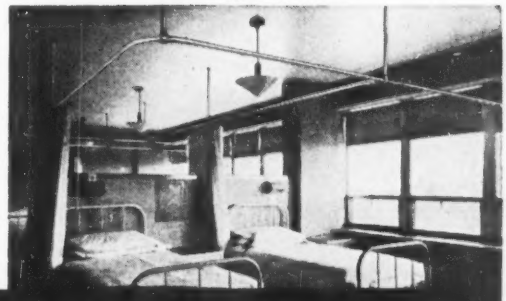
1141. New X-ray trouble chart available—11 x 15" chart, "Locating Common Electrical Faults in X-Ray Generators." Developed to aid plant engineers and laboratory technicians, it lists symptoms, suspected location, trouble possibilities, and methods for locating and correcting generator troubles common to all types of x-ray generator equipment. North American Philips Co., Inc.

1183. Fine quality, low-priced stainless steel knife for table use is made with solid one-piece construction so that the blade and handle can never become loose or separated. Finest quality cutlery stainless steel, polished to a mirror finish, makes it easy to keep this knife bright and gleaming with ordinary soap and water washing. Made entirely of heavy gauge material, specially hardened blade insures long life and prevents dulling of the very keen edge. Bloomfield Industries, Inc.

1117. Entrance Mat made with a triple-ridged surface top and diagonal ridges for drainage on the under side. Constructed from a rubber compound which has been increased in tensile strength so that unwashable cord has been eliminated. Priced 15 percent lower than the old type corrugated-perforated mats of similar thickness. Manufacturer claims that the top surface of the mat will remove more dirt than the surface of any molded mat made. The American Mat Corp.

(Continued on next page)

AMERICA'S GREATEST NAME IN HOSPITAL CUBICLES!



CAPITAL CUBICLES

AVAILABLE IN:
BRASS • STAINLESS STEEL
ALUMINUM, LUSTROUS FINISH

OUTSTANDING ADVANTAGES!

COMPLETE PRIVACY:
Installed in wards, semi-private, first aid, examination rooms; and in x-ray, hydrotherapy, dental, basal metabolism and other departments. Capital Cubicles provide maximum light and air, and enable nurses to render quicker medication and attention to the patient.

SMOOTH, EFFICIENT OPERATION:
Patented features of Capital Cubicles prevent hooks from catching or jamming, and assure quick, quiet, dependable operation.

EASY INSTALLATION:
Delivered complete with each cubicle and curtain keyed. Quickly installed with conventional carpenter's tools or, if desired, we will install at nominal cost.

LOW COST:
The initial cost of Capital Cubicles are the lowest on the market. *There are no maintenance costs to consider!*

CURTAINS:
Capital Cubicle curtains are of special closely-woven jean cloth, non-transparent and sanforized shrunk. In white and restful fast colors. Substantial rust-proof eyelets will not pull out or stain the cloth.

CURTAIN HOOKS OPERATE INSIDE TRACK . . . CANNOT BE REMOVED OR LOST. CANNOT SCRATCH FINISHED SURFACE.

SEND FOR ADDITIONAL DETAILED INFORMATION
. . . include rough sketch of room, indicating bed positions. We will submit plans, specifications and cost. No obligation, of course.

CAPITAL CUBICLE CO., INC.
213 25th STREET, BROOKLYN 32, N. Y. • SOuth 8-1022

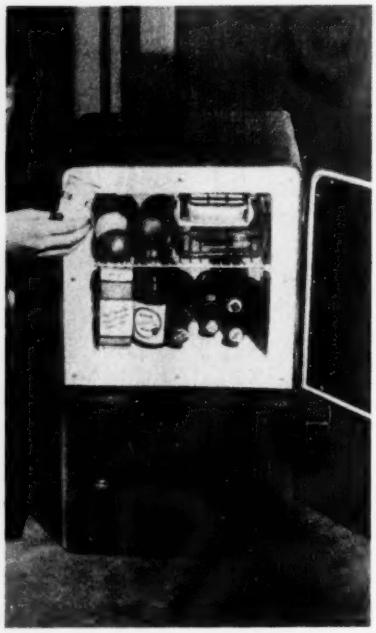
BUYER'S GUIDE

1186. "Handy Fire Dolly" is equipped with three fire extinguishers designed to combat all types of fires. Mobile unit is easily wheeled to the emergency area where the proper extinguisher can be selected and put to immediate use. Includes General Quick Aid Vapo-Liquid Fire Guard for fires caused by gasoline, oil, grease, paints, and inflammable liquids; Dry Chemical Fire Guard for all types of electrical fires; and a General Quick Aid Water-Type Fire Guard containing an anti-freeze charge, making it practical for inside or outside use. The General Detroit Co.

1173. Chloropads, disposable protective bed pads, in both special and standard sizes, are impregnated with a special Airkem formula containing chlorophyllins for added freshness and a potent quaternary ammonium bactericide to inhibit the growth of odor-forming bacteria. Formula does not disturb the absorptive qualities and binding elements of the pads. Pads are made for use in normal and gross drainage cases, perspiration odors, maternity cases, care of incontinents, and after-surgery cases. Soft green tint. The General Cellulose Co.

1176. Maid-Easy Coffee Stain Remover helps to eliminate bitter coffee taste. Odorless, economical, and easy-to-use compound. Residual oils and stains that seem impervious to cleaning are quickly removed from urns and pots. Also can be used to remove unsightly stains from plastic and other dinnerware. Maid-Easy Cleansing Products Corp.

1172. "Once Over," all-purpose industrial cleanser, used in solution with warm water, can be used on virtually every type of surface. A blend of four non-alkaline ingredients, it is mild as any toilet soap and forms suds and foam in the hardest water. Mopped liberally on the surface, it is allowed to remain there for six to eight minutes while the cleaning action takes place, then it is mopped up. Surfaces do not ordinarily have to be rinsed. Will work equally well on rough concrete floors or the finest waxed woodwork. Can also be used on linoleum, plastic, and rubber floors, dishes, pots and pans, hospital beds, venetian blinds, metal or leather furniture, etc. Gerson-Stewart Corp.

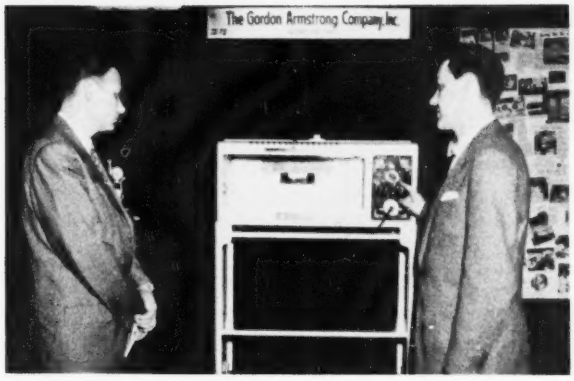


1170. P.S. Junior Refrigerator is only 28½" high, 16" wide and 19½" deep — occupies two sq. ft. of floor space, but has a full cubic foot of refrigeration area. Makes 21 ice cubes in a one-piece, odorless U. S. Rubber "Royalite" plastic food chamber that has rounded corners for easy cleaning and a 9-point adjustable thermostatic control. Below is a quiet motor and a ¾ cubic foot dry storage compartment. Walnut, white or ivory finish. Durable Formed Products, Inc.

1155. Hubbellite, inorganic copper-bearing floor surfacing cement makes a static-draining floor for hospital operating rooms, which reduces the possibility of anesthetic gas explosions. Has excellent resistance to heavy foot traffic. Non-dusting. May be laid with a trowel finish like ordinary cement, or can be used as a Terrazzo binder. Seven attractive basic colors. Hubbellite Corporation.

1171. New casement window storm sash designed for indoor installation. Aluminum-framed glass inserts slide freely over special zinc alloy runners inside a protective aluminum rail. These inserts are overlapped and sealed by a plastic strip running along the edge of each section, making the storm sash practically air-tight. Easily opened or removed for cleaning. Wide space between outer and inner windows reduces fogging and condensation. Weather Products Corp.

1177. "Kiddy Kartoon" bed gowns and pajamas for both boys and girls. The cartoon designs include the entire animal kingdom in a gay and cheerful array of colors on either yellow or blue backgrounds. Garments are made of sturdy, vat-dyed sanforized twill. The sleeves are roomy and full cut; all strain points are reinforced. Pajama coats have indestructible cloth knot buttons. Angelica Uniform Co.



Jay Dorsale, Gordon Armstrong Co., Inc., explains the features of the Armstrong Explosion-Proof Baby Incubator (see below) to W. L. Boucher, M.D., Henry Ford Hospital, Detroit, Mich., as he stops at the booth at the recent meeting of the American Academy of Obstetrics and Gynecology.

1044. Armstrong Explosion-Proof Baby Incubator — safe for delivery room or surgery. UL approved. Safe, gentle heat passes into incubator by radiation. Thermo-switch automatically turns heat on and off to maintain desired temperature and humidity. Heating unit is serviced free for a three-year period. Permanent instruction panel is mounted in plain sight on back wall. New oxygen inlet nipple is featured. The Gordon Armstrong Co.

919. New Visi-Shelf X-Ray Negative Filing Cabinet for economical filing of x-ray negatives. Sturdy, all steel unit, embodies all the features necessary for easier filing, besides being capable of holding twice as many negatives as ordinary file cabinets in half the floor space. Visi-Shelf File, Inc.

920. Attractive "Puppy" and "Kitty" rubber water bottles, so popular with children, are again being restored to the sundries line of B. F. Goodrich Co. The full pint capacity bottles are available in pink and blue colors. B. F. Goodrich Co.

1041. Hypodermic Needle Sharpener—can produce rounded bevel, which in effect reduces needle several gauges. This type of needle is more easily inserted—minimum bleeding when needle is withdrawn. Sharpener grinds a new and improved needle point in five seconds—can produce nine different points. Rauh & Co., Inc.

1042. Misty Green Operating Room Linens and Garments provide glare-proof visibility, reducing muscular tension, visual, and general fatigue. Vat-dyed, fast color, even after repeated washings. Kuttnauer Mfg. Co.

The Buyer's Guide is a service to readers. Listing of products in the Guide does not constitute endorsement by HOSPITAL TOPICS.

1197. New Model "MM" two-tank extra capacity automatic dishwashing machine will handle 5,000 dishes per hour with 2 H-P motor. Pre-assortment of dishes before washing saves handling after sterilization. When through the final 180° sterilizing rinse, the dishes are ready for immediate re-use. Machine has pre-scraping features. Universal Dishwashing Machinery Co.

1118. Newly improved linen marker for applying dry transfers, now features heating element in a complete unit, which is easily replaced when necessary. Temperature is automatically maintained within correct range for marking all types of fabrics. A screw on top allows adjustment of temperature for each type of fabric. Iron rest is cast in one piece with housing. It has more efficient cooling vents and ground connection on rubber cord to provide complete safety. Evermark Div. of The Roderking Corp.

1198. CGS plastic diascope allows for minute examination of all areas of the face, fingers, as well as general examination of the body. The marking on the side indicate centimeters, with the small markings, millimeters. With the aid of these markings, the size of lesions can be given more accurately. The diascope may be used also as a tongue depressor and for examination of the mucous membrane. Convenient size to carry in a pocket. Cleansing is done easily with alcohol or soap and water. The CGS Co.

(Continued on next page)

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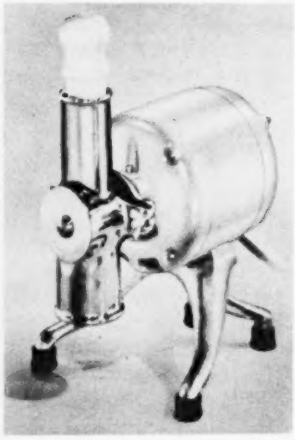
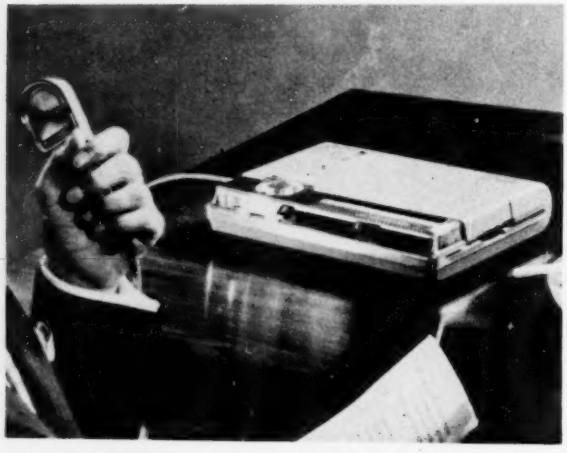


1115. Food Shredder designed for preparing special diets which call for freshly shredded fruits and vegetables. Simple to use. Constructed for quick and easy cleaning. Operates on 110 volts AC. Finished in stainless steel and white porcelain. Knuth Engineering Company.

1074. Melmac Orthopedic Composition, a plastic powder used in making superior orthopedic casts. Strength of casts is so much greater that the casts can be made two-thirds lighter in weight. Even though they are thinner, they still provide adequate immobility and support within a few hours after application. Casts are porous enough to permit evaporation of moisture from the skin. Thinness of cast permits greater x-ray penetration. Water and urine-resistant and can be soaked several days without disintegrating. Davis & Geck, Inc.

1127. Tray Cards in eight distinctive colors for modern, simplified hospital routine. Speed work of dietitians and nurses, provide added safety for patients. Wide assortment for all types of diets. Adaptable to routine of every hospital. Space for patient's name and room number. Made of bristol board with good writing surface. Economical to use. Physicians' Record Co.

1114. Special Diet Foods using Sucaryl Calcium (Abbott Cyclamate) for sweetening are available. Soup bases, gelatin desserts, and beverage concentrates. Ad. Seidel & Son, Inc.

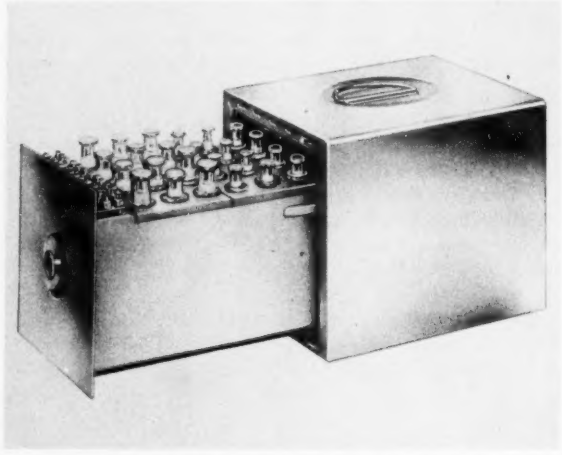


1106. The Edison VP Voicewriter, smallest and lightest all-purpose dictating machine devised after two years of laboratory research. Lighter by 25 percent than any other machine and small enough to be tucked under the arm or carried in a brief case. Low priced. Includes a microphone which also serves as a speaker, Vinylite "diamond discs" which have a 30-minute dictation capacity, a "4-in-1 control" knob, and operates on only 25 volts of AC current, or with a converter. Thomas A. Edison, Inc.

1004. New synthetic fiber, fireproof drapery material having the appearance, feel, and draping qualities of wool. Unlike sprayed or vat-dipped temporary fireproofing, Infinity Fireproof Fabrics are permanently and inherently flameproof. No treatment required. Nothing to crystallize, flake off, evaporate or wash out. Mildewproof, mothproof, have dimensional stability (shrinkage and stretching are eliminated), dry rapidly, need no ironing, and are very tough fibers under all climatic conditions. Edwin Raphael Company, Incorporated.

992. New type of walking aid, different from the old-fashioned crutch or cane, a rugged four-legged support, so light that a child can carry it in one hand. Stands waist high, and the 18-inch handle bar at the top makes leaning-on easy. Gives all the support of a table. Easily adjustable to a flat unit. The Anchor Mfg. Co.

1112. The explosion hazard of static electricity in inflammable gas or dust filled rooms can be removed by checking the conductivity of the floors and other equipment with the Midget Megger Floor Tester Kit. Kit complies with the National Fire Protection Association's "Recommended Safe Practice for Hospital Operating Rooms." James G. Biddle Co.



1138. Steri-file sterilizers 24 syringes, 24 needles at one time without wrapping. No handling necessary after autoclaving. 2cc—5cc—10cc sterile syringes—all size needles, ready for instant use. Midland Equipment Co.

1076. Automatic Safety Nursery Camera. Infant is photographed right in his own bassinet. There is no violation of sterile technic. Unit is safe, compact, and completely portable. Engineered for complete protection and electrically isolated to eliminate all hazards. Completely automatic. Hospital does not buy or rent camera, does not sign contract, is fully insured by company against personal and property damage, and receives 25 percent of gross proceeds from the sale of the pictures. Hospital Photo Guild, Inc.

1089. Liquid germicide Santophen 1 Solution is effective against both fungi and bacteria, consists of 75 percent by weight Santophen 1 and 25 percent isopropanol. In addition to its stability and ease of handing, the solution eliminates one step in preparing germicidal formulations which involve the use of isopropanol. Can be used for a variety of purposes, including sanitizing restrooms, disinfecting floors, walls and equipment in hospitals. Monsanto Chemical Co.

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☐	971 Deeminac	☐	1151 Metal Bedside Cabinet	☐	1186 Handy Fire Dolly
☐	992 Walking Aid	☐	1152 Crescent Food Conveyer	☐	1187 Plumbing Book
☐	1004 Infinity Fabrics	☐	1154 Mallinkrodt Ether	☐	1188 Thank You Folder
☐	1041 Rauh Needle Sharpner	☐	1155 Hubbellite	☐	1189 Clarke Vacuums
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In 16-oz. bottles.

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1152. Hot-Cold Crescent Food Conveyer for handling pre-protioned meals. Designed for use with a special heated platter serving system. Each of the four "hot" compartments on the left holds 12 individual pre-portioned meals. The two compartments on the right are for cold storage. Dispensers for coffee and other liquids are mounted on the back wall just above the working counter. Constructed of aluminum, with four swivel-type casters with rubber treads. Crescent Metal Products, Incorporated.

1154. Mallinckrodt Ether for Anesthesia now packaged in an improved can with better storage qualities. Improved containers provide further protection against such undesirable changes as the formation of aldehydes and peroxides. New red, black, and white label provides greater legibility than the familiar old one. Available in ¼, ½, 1, and 5 pound cans. Mallinckrodt Chemical Works.

1175. New low-cost Stereo-Microscope, used for any inspection operation, examination, counting, checking, or dissecting, has wide range, erect image, deep focus, and long length of working space. Fixed 3-power objective, with three pairs of matched eye-pieces to give powers of 15X, 30X, 45X. Rack and pinion focusing. Interpupillary adjustment. Has focusing eye-piece for eye compensation. Instrument is removable from base for mounting on equipment, bench, or stand. Working distance is 2¾" — adjustable for extra height. Edmund Scientific Co.

1196. Disposal featherweight aluminum cooking container. Weighs only one quarter of an ounce, yet is strong enough for cooking casserole dishes, serving, freezing, and storing. Circular in shape, 1½ inches deep, 3¼ inches across the bottom and 4½ inches across the top. Matching aluminum lids provide an airtight seal. Reish Products, Inc.

1174. Plasticon, new kind of hospital sheeting made of durable lightweight plastic material, is suited for practical hospital use because it remains smooth, soft, and extremely pliable even after repeated washings. Laboratory tests prove that sterilizing, autoclaving, and washing (using mild soaps and detergents) do not harm or "bleed out" the plasticizers used in this film. Locked in plasticizer eliminates tendency for sheeting to become sticky and messy. Crease-wrinkle-stain-resistant. Non-toxic — does not support combustion and is self-extinguishing. Water-oil-grease-proof. Lightweight, easy to cut and handle. Continental Hospital Service, Inc.

1202. Complete Audio Catalog contains illustrations and descriptions of high fidelity home music system components, public address, institutional, recording and broadcast equipment as well as audio test instruments and similar specialized equipment. Terminal Radio Corp.

(Continued on next page)

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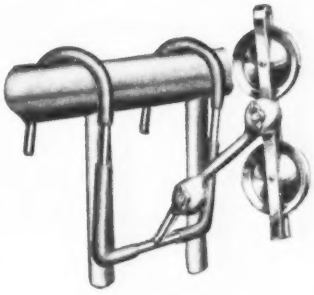
FOR use in the Russell method and the Buck method of treating fractures of the femur, Orthopedic has developed a complete line of extension appliances. They are easy to hook over end of any style bed. Simple to keep clean. No rough surfaces to catch on bed clothes or traction cord.

Pulleys, of stainless steel, are free turning.

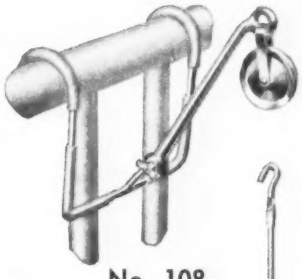
The adjustable double pulley extension hook, No. 56E, indicated in Russell's method of treatment, has two ratchet and wing nut adjustments, providing wide range of tensioning positions. This unit is available complete with knee sling, foot piece, traction cord and weight carrier and weights totaling 10 lbs.; our catalog No. 56A.

Adjustable extension hook, No. 108, indicated in Buck's method of treatment and other traction applications, has a single ratchet and wing nut adjustment. Fits any bed.

Send for 124-page cross-indexed catalog describing these and other fracture appliances and splints.



No. 56E
No. 106A is clamp on type (not shown) Has adjustable frame.



No. 108

Weights
No. 183A 5 lbs.
No. 183B 2 lbs.
No. 183C 1 lb.

Carrier No. 176

Orthopedic EQUIPMENT CO.
150 FORT WAYNE STREET
BOURBON, INDIANA

New Literature

1199. Mills Movable Metal Walls described in catalog containing layouts, installation, and construction photos and complete specifications data. Mills Co.

1188. "Thank You," folder tells how the nurse studies hard, and works unselfishly to bring back health to those who enter the hospital, an often neglected part of public education. Through this book, patients and their friends learn about the nurses' work, and are more appreciative of good care and more indulgent when the nurses are delayed in answering their call. This improves reactions of patients and relatives, with nurses. Space on the outside of the booklet for the hospital's name and picture, if desired. Sample available. Physicians' Record Co.

1187. Plumbing Fixtures for Hospital Planning. Book designed to help hospital administrators, architects, engineers, and plumbers in the selection of plumbing fixtures and fittings for modern hospitals. Includes floor plans of different departments of a typical hospital. Shows and describes various plumbing fixtures like lavatories, special hospital-type sinks, baths, water closets, and therapeutic equipment. American Radiator & Standard Sanitary Corp.

1191. "101" Hints on Better Floor Care" — 28-page booklet of valuable tips on floor care and containing all the latest developments. Huntington Labs., Inc.

1189. New WD-23 and WD-15 wet-dry vacuum cleaners described in a colorful folder. Gives complete specifications on the two wet-dry vacuums along with pictures and descriptions of a long list of available attachments which make the vacuums all-round cleaning instruments. Clarke Sanding Machine Co.

1190. Nurse Recruiting Folder tells the opportunities of nursing for secure, interesting, satisfying career. There is a space on the outside of the booklet for the hospital name and a picture of the hospital, if desired. Sample available. Physicians' Record Co.

1203. "Chlorophyll in Medicine." The story of chlorophyll in medicine and its clinically substantiated properties as an aid to normal healing are described comprehensively in a new booklet. Rystan Co., Inc.

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E. coli	15 min.	3 min.
Strept. hemolyticus	15 min.	15 sec.

PRICE
Per Gallon $5.00
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No. 300 B-P INSTRUMENT CONTAINER is suggested for your convenient and efficient use of BARD-PARKER CHLOROPHENYL. Holds up to 8" instruments.

Ask your dealer

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Danbury, Connecticut

New Films

1193. New Medichrome Series on Public Health Nursing. 193 2 x 2", 35mm. Kodachrome photographs show the various activities of the Public Health Nurse. A teaching syllabus is available with the slides. Clay-Adams Co., Inc.

1194. New catalog listing more than 600 of Hollywood's outstanding feature films available to schools, shut-ins, hospitals and correctional institutions. 16mm. Films, Inc.

1200. Film Rental Catalog — 1953. Communication Materials Center.

1192. Surgical Film Library Catalog. 21st edition published by Davis & Geck, Inc.

1195. Protestant Religious Catalog of film strips, slides, and slide sets. Also shows equipment, accessories, and replacements for showing of films. Society of Visual Education, Inc.

New, revised Medical Film list which includes 78 medical films not readily available from other sources. List may be obtained by writing to the Committee on Medical Motion Pictures, American Medical Association, 535 N. Dearborn St., Chicago, Ill.

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THE LAB

A regular feature for Medical Technologists

21st ANNUAL ASMT CONVENTION, BROWN HOTEL, LOUISVILLE, KY., JUNE 14 - 18

The Potassium, Sodium and Calcium Content of Gastric Juices. 1. Normal Values

By Ralph E. Bernstein, M.Sc., M.B., Johannesburg, South Africa. Abstracted from Journal of Laboratory and Clinical Medicine, Nov. 1952, Vol. 40, No. 5, page 707.

Summary:

1. The estimation of potassium, sodium, and calcium by a method of internal standard flame spectrophotometric analysis is described. Sources of interference are adequately corrected by the incorporation of lithium as internal standard. The technic is rapid and of a statistical accuracy superior to chemical analysis and direct flame photometry.
2. Fasting and resting values of potassium, sodium, and calcium in gastric juice of 50 young healthy male adults are presented, and the variations in these cations during histamine and insulin tests of gastric function have been followed in 39 subjects.
3. The dissociated response of the different glandular elements of the stomach is evidenced from the consistent sequence of change in gastric juice potassium and calcium to histamine and insulin stimulation. The high correlation coefficient of total chloride to free acid in such specimens indicates that they can be considered as pure gastric juice in most instances. It would appear that calcium in filtered gastric juice is derived from the nonparietal component of gastric juice, probably mucous secretion. Potassium is present both in the parietal and nonparietal components of gastric juice and alterations during acid secretion may be related to a membrane ion-exchange of hydrogen and base and the increased potassium uptake by the gastric mucosa during active metabolism as major factors.
4. Hyposecretors have gastric juice potassium and calcium values higher than normal, and undergo less change after histamine or insulin injection.

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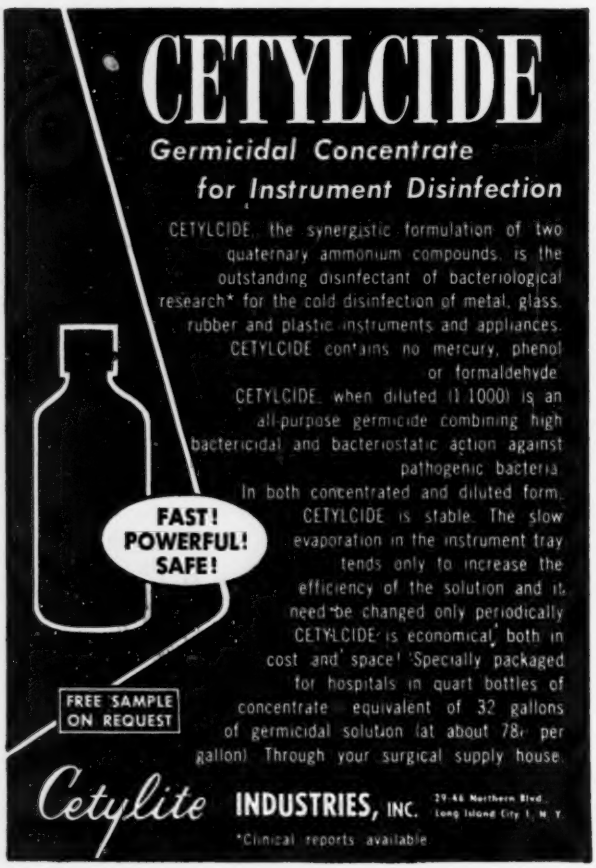
Deeminac comes in three sizes — 6 oz. bottle with 2 oz. filter distills up to 20 gallons, $1.75; (8-3) 30 gallons, $2.25; (16-4) 40 gallons, $3.00. Color change in filter indicates need for refill. Refills are 2 oz., $1.25; 3 oz., $1.75; 4 oz. $2.25.

For further information check no. 971 on the reply card.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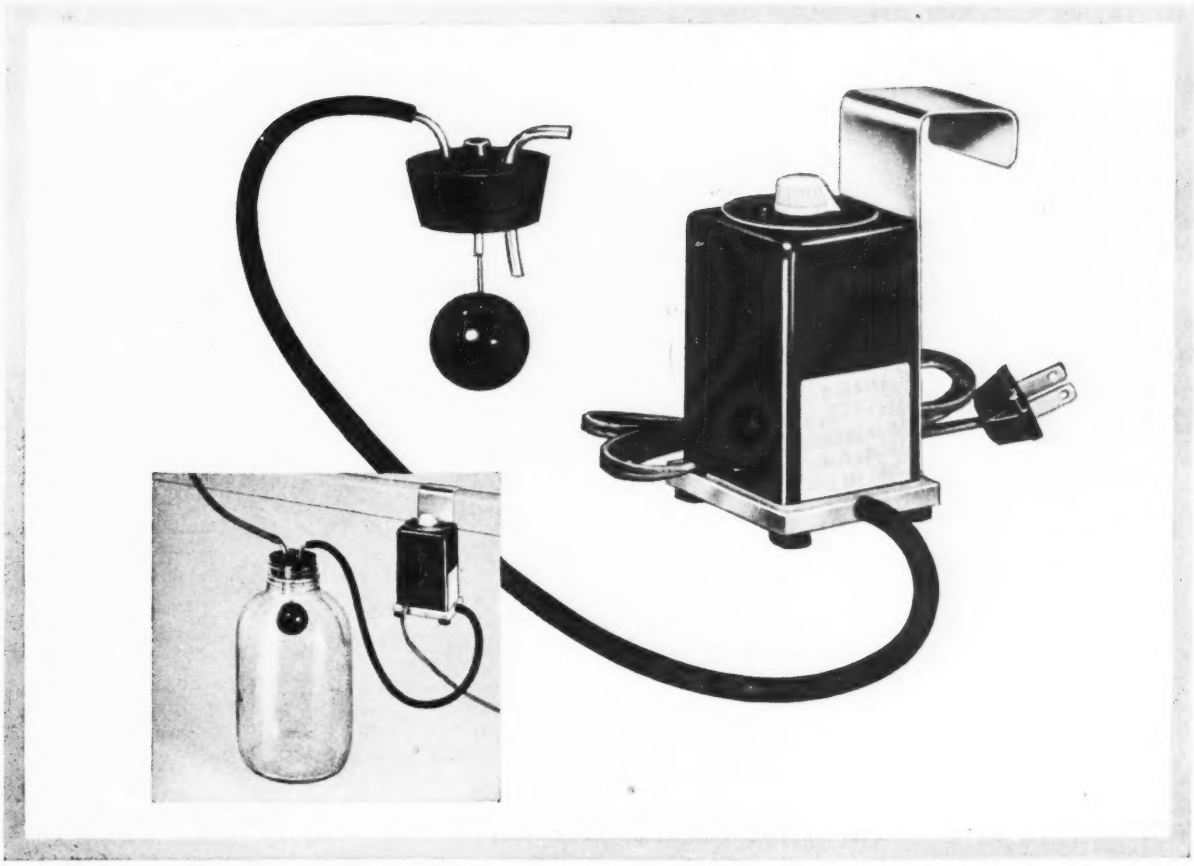
TECH NOTES

● National Laboratory Open House will be held this year during the week of May 10-16. It is not too early to start planning what type of program you will be having.

● The Denver Society of Medical Technologists has invited Dr. Essie White Cohn, professor of chemistry, University of Denver, to address its March 5 meeting.

Speaking on "High Altitude Research," Dr. Cohn will discuss her work in biochemical research using animal experiments at the Inter-University High Altitude Laboratory. The laboratory is located 75 miles from Denver and is situated at 14,150 feet on Mount Evans. Because of climatic conditions during the winter months, experiments are usually made at the laboratory from June until September or October. Dr. Cohn is in charge of the Division of Chemistry and began her work with experimental animals in 1948 at the Mount Evans laboratory.

● Ellen Skirmont, member of the ASMT public relations committee, recently became the bride of W. G. Diffenbaugh, M.D. Dr. Diffenbaugh is associated with St. Luke's Hospital, Chicago. She is medical technologist at the Argonne National Laboratories.



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This efficient new vacuum pump has all the power necessary for mild drainage and aspiration, yet the power unit itself occupies only 2½ inches of space, and is offered at a fraction of the cost of conventional pumps. Dial control makes possible variable vacuum from 2 to 15 inches; air displacement up to 600 cubic centimeters per minute. Supplied complete with special float which fits ½- or 1-gallon Mason type jars. The unit is sealed in a black case mounted on machined aluminum base. Base mounted on sponge rubber feet — will not "crawl." An aluminum bracket is supplied to attach pump unit to bed rail. Unconditionally guaranteed for one year.

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Aloe Out-O-Way Drainage Bottle Holder

Recommended for use with Aloe Vacuum Pump listed above. Eliminates accidents with drainage bottle; fastens to angle iron of bed by means of adjustable catch. Holds gallon Mason jars, Fowler bottles, or hospital food jars.

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DePuy Celebrates 58th Anniversary

This could be titled, "A birthday party picture" since it shows the banquet meeting culminating the 58th Anniversary sales meeting of the staff and field representatives of the DePuy Manufacturing Company, Warsaw, Indiana. TOPICS adds its best wishes for 58 more birthdays to this pioneer company in the orthopedic and fracture appliance field.

TRADE TOPICS

New Virus Research Laboratory Opened

Highly hazardous and infectious diseases are being studied at close range in the new virus research laboratory completed by Parke, Davis & Co.

The specially-designed building allows more critical studies of every type of virus investigation, Dr. Leon A. Sweet, vice-president and director of research for the firm, disclosed.

Under supervision of Dr. F. D. Stimpert, director of microbiological research, Parke-Davis scientists are conducting important experiments involving polio, "Q" fever, the common cold, mumps, measles, and other highly infectious diseases which are difficult in ordinary laboratories.

The new virus laboratory is a one-story brick and steel structure, 100 feet long and 40 feet wide. It constitutes a compact, self-contained unit made up of five working rooms which can be sealed off and decontaminated quickly and easily. A special enamel finish on the walls allows steam or disinfectant sterilization and decontamination.

Isolation units for several thousand animals hold cross-infection to a minimum. In one room, each monkey has an individually-regulated and air-conditioned cage. In the ordinary laboratory, scientists are frequently handicapped by the involuntary infection of some animals by others.

Appointments

Dr. Harold H. Golz has been named an assistant medical director, American Cyanamid Co., New York City. He had been assistant to Medical Director, **Dr. D. O. Hamblin,** for one year.

Dr. Golz will supervise Cyanamid's industrial hygiene and toxicological programs and plant medical departments, except those of Calco Chemical Division.

Before joining Cyanamid, Dr. Golz was chief of the medical service and chief of staff for the Arabian American Oil Co., in Saudi Arabia.

Arthur F. Bleiweiss has joined Prometheus Electric Corp., New Rochelle, N. Y., manufacturers of hospital, surgical and dental equipment, as vice-president in charge of engineering and manufacturing. Formerly vice-president of the Radiant Lamp Corp., Mr. Bleiweiss has been associated in research with **Dr. Gustav Bucky,** roentgenologist and physicist, in the development of lighting and therapeutic devices.

Mr. Bleiweiss

B. W. Goulding has been appointed vice-president in charge of the Liquid Carbonic Corp.'s Compressed Gas Division. In his new duties Mr. Goulding will be completely responsible for sales, manufacture, and distribution of the division's products.

Mr. Goulding is now located at the home office in Chicago.

Mr. Clauson

Earl A. Clauson, Nebraska district sales manager for Abbott Laboratories, has been transferred to district sales manager of the Chicago district.

Mr. Clauson has been in charge of Abbott's Nebraska district since 1950, stationed at Omaha. He previously was a medical service representative at Madison, Wis., having joined Abbott in 1932.

Named to replace Mr. Clauson as Nebraska district manager was **Paul B. McKibben,** medical service representative at Lincoln. Mr. McKibben has been with the Abbott sales organization since 1933.

Mr. McKibben

Wyeth Honors Barbara Eater

It was Barbara E. Eater's Day at Wyeth's Marietta, Pa., Laboratories, Jan. 7. Several hundred employees gathered to honor this spry lady of 70 on her golden anniversary in the biological and pharmaceutical business. Miss Eater is an inspection supervisor.

Harry S. Howard, president of Wyeth, presented her with a gold wrist watch. She also received a scroll of commendation and appreciation.

Robson of Wilmot Castle Dies

Norman S. Robson, who until a year ago was manager of the Hospital Department, Wilmot Castle Co., Rochester, N. Y., died Nov. 17. His death occurred following a long illness which was subsequent to his retirement early in 1952.

Frank Rice, associated with the Hospital Sterilizer and Hospital Light Division for many years, is now manager of the Hospital Division.

Personally Speaking

James H. Abbott—has been appointed assistant administrator, Hospital of the Good Shepherd, Syracuse University, Syracuse, N. Y. He replaces **Joseph B. Fowler**, who resigned to become administrator, Cortland (N.Y.) County Hospital. Mr. Abbott was formerly with the U. S. Public Health Service, Washington, D. C.

Arthur C. Bachmeyer, M.D.—director emeritus, University of Chicago Clinics, has been named study director of the Commission on Financing of Hospital Care. He succeeds **Graham L. Davis**, who resigned for reasons of health. Mr. Davis, after an extended rest, will return to his position as director of the hospital division, W. K. Kellogg Foundation, Battle Creek, Mich.

John H. Beddow—is now administrator, West Hudson Hospital, Kearny, N. J. He succeeds **Drew J. Thomas**, who recently became director, Nathan Littauer Hospital, Gloversville, N. Y.

Jack Eugene Blume—employed as laboratory technician, Perry County Memorial Hospital, Tell City, Ind.

Letta Bracken—has resigned as administrator, Springdale (Ark.) Memorial Hospital.

Ralph I. Burris—named administrator, Sturgis (Mich.) Memorial Hospital.

James W. Colbert, Jr., M.D.—has been appointed dean, St. Louis University School of Medicine. When he assumes his duties in March, he will be the youngest dean of any major medical school in the United States. He was 32 years old on Dec. 14. Dr. Colbert was formerly assistant dean in charge of postgraduate studies, Yale University School of Medicine.

James G. Carr, Jr.—will be administrator, Memorial Hospital of Natrona County, Casper, Wyo., succeeding **W. B. Haselmire**, who has resigned, effective Apr. 1. Mr. Carr, formerly fiscal and personnel officer and assistant hospital superintendent, University of Nebraska Hospital, Omaha, was succeeded by **Duane Johnson**, formerly administrator, Audubon (Ia.) County Memorial Hospital.

William Cotton—is administrator, Erie (Pa.) Osteopathic Hospital.

Mrs. Virginia G. Cummins—is the new chief dietitian, Conemaugh Valley Memorial Hospital, Johnstown, Pa., succeeding **Mrs. Anne W. Fitzpatrick**, who has resigned. Mrs. Cummins has been therapeutic dietitian at the hospital for the last two years.

George E. Currier, M.D.—has been named superintendent, Eastern Shore State Hospital, Cambridge, Md. Also appointed as superintendents of Maryland state mental hospitals were: **Arnold Eichert, M.D.**, Crownsville State Hospital; **Robert E. Gardner, M.D.**, Springfield State Hospital, Sykesville; **George C. Medairy, M.D.**, Rosewood State Training School, Owings Mills; and **Isadore Tuerk, M.D.**, Spring Grove State Hospital, Catonsville. Drs. Gardner, Medairy, and Tuerk have been acting superintendents. Dr. Eichert, who succeeds **Jacob Morgenstern, M.D.**, at the Crownsville Hospital, was formerly clinical director, Spring Grove State Hospital. Dr. Currier was in private psychiatric practice in Lowell, Mass.

Lillie L. Deimler—resigned as educational administrator, Mercy Hospital School of Nursing, Urbana, Ill.

Eva M. Dickson—has resigned as superintendent, Greenville (Pa.) Hospital. **William Eddy** is acting superintendent.

Mrs. Lena Dixon Dietz, R.N.—has resigned as director of nurses, Passavant Hospital School of Nursing, Jacksonville, Ill. She will return to the State University of Iowa, from which she was graduated, to work on revisions of two textbooks which she wrote for student nurses.

John Danielson—is the new assistant director, Roosevelt Hospital, New York City, succeeding **Peter B. Terenzio.**

H. H. Donahue, M.D.—resigned as assistant medical director of Texas state hospitals.

Robert E. Eckelberger—administrator, Wilson Memorial Hospital, Johnson City, N. Y., will be acting superintendent, Ideal Hospital, Endicott, N. Y., while **Robert T. Johnson**, Ideal's superintendent, is away on sick leave. Mr. Eckelberger will continue to hold his position at Wilson Memorial Hospital. **Mrs. Margaret Dorr**, office manager at Ideal Hospital, has been named to head the hospital's business office and general administration. **Karl D. Rundell, M.D.**, chief of medical staff, has been given the power of emergency administration decisions.

Daniel G. Falvey—formerly admin-

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ADMINISTRATORS: (a) Medical; 600 bed general hospital; $15,000; fine home; West coast. (b) Lay; 2 hospitals; 400 beds; large city, South. (c) Medical or lay; teaching hospital; 350 beds; starting construction.

ADMINISTRATIVE STAFF: (a) Personnel director; new post; 600 bed hospital; university city; South. (c) Controller; 450 bed hospital; city 95,000. (d) Business Manager; general hospital, 240 beds; university city; Southwest. (g) Purchasing Agent; 400 bed hospital; $5,000.

ADMINISTRATORS-NURSES: (a) Small hospital; expansion program; town 100,000; California. (b) Small general county hospital; not too far from Denver. (c) Assistant: 30 bed general voluntary hospital; $5,000; Florida. (e) New hospital; 20 beds; near Yellowstone & Sun Valley. (g) General hospital, 50 beds; $6,000; Indiana. (h) Combined administrator & director, nursing service; general hospital; 60 beds; Iowa. (i) Assistant; woman's hospital; 250 beds; university city; East.

DIETITIANS: (b) Chief; 300 bed Tuberculosis voluntary hospital; California. (e) Administrative; responsible for main kitchen, cafeteria & therapeutic diets; general voluntary hospital; 650 beds; college city 180,000; New England. (f) Chief; new general voluntary hospital; 300 beds; ADA; 2 assistants; 30 employees; full maintenance; lovely apartment, new nurses home; near New York City.

DIRECTOR OF NURSES: (a) Director of Nursing Service & Education; general voluntary hospital 400 beds; 130 students; 1 class yearly; university affiliated; requires outstanding woman with academic interest; around $7500; 2 bedroom apartment; East. (b) Children's hospital; 300 beds; department staffed with competent assistant & educational director; 90 students; outstanding medical staff; minimum $6000; West-coast.

EXECUTIVE HOUSEKEEPERS: (a) Teaching hospital; competent assistant & staff of 50; will have department head status; prefer man; around $6000; Midwest.

FACULTY APPOINTMENTS: (a) Educational director; university school; woman of outstanding attainments; Masters or PhD; qualified direct entire program; faculty appointment. (f) Clinical Instructor in obstetrical nursing; voluntary general hospital 400 beds; NNAS; opportunity continue studies; university medical center.

MEDICAL RECORDS LIBRARIANS: (a) Chief; newly organized department; voluntary general hospital 120 beds; $400; one of larger towns; Alaska. (d) Competent experienced woman to direct department; staff of 50; unit system; teaching hospital 600 beds; large city; university medical center; South.

THERAPISTS: (a) Occupational Therapists qualified to direct rehabilitation center; college town 175,000 near Chicago; around $6000.

POSITIONS WANTED

ADMINISTRATOR: Medical; degrees from leading schools; six years, assistant director, university hospital; five years, administrator, important voluntary general hospital, 450 beds; FACHA.

ADMINISTRATOR: B.S., Business Administration; B.S., Education; C.P.A.; Master's, Hospital Administration; 4 years, director, voluntary general hospital, 150 beds; currently, administrator, important research, medical center hospital. Member, ACHA.

COMPTROLLER: C.P.A.; Ten years, consultant, Blue Cross and all affiliated hospitals, same period, audits, voluntary general hospital, 500 beds.

PATHOLOGISTS: Diplomate, Pathologic Anatomy, Clinical Pathology; seven years, director, pathology, university hospital; two years, assistant professor, pathology, university medical school.

DIRECTOR OF NURSES: B.S.; Master's, Abnormal Clinical Psychology; one year, director, psychiatric nursing program and assistant professor, important school of nursing; seeks nursing administration or education psychiatric hospital with university affiliations. Early thirties: single.

RADIOLOGIST: Diplomate, (Therapy & Diagnosis); Five years, Professor, radiology, university medical school and director, Department Radiology affiliated 500 bed graduate hospital. Outstanding man.

PHARMACIST: Ph.C., one of leading universities; Fifteen years, Chief Pharmacist; university hospital; currently, instructor and supervising pharmacist, university college of pharmacy.

(Additional classified on pages 52, 70)

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HOUSEKEEPERS: (a) Male Executive Housekeeper; 365 bed hospital, middlewest; capable directing challenging program; $5000. (b) Executive; East 150-bed general hospital, facilities complete and modern, located in city of 15,000; $3600-$4200 maintenance. (c) Executive; Middlewest, 225-bed hospital, pleasant community in easy commuting distance from Chicago; $3600 maintenance. (d) Executive; Middlewest, 265 bed hospital; capable directing and administering complete housekeeping program; $5200 maintenance. (g) Assistant; middlewest, 150-bed hospital, modern, located in city of 100,000; $3600 maintenance. (e) Assistant; east, 250-bed general hospital, complete modern facilities; $3600 maintenance. (i) Assistant; southwest, 200-bed general hospital in city of 500,000; department well staffed; $3600 maintenance. (j) Assistant; east, 370-bed general hospital fully approved, located in city of 50,000; $3600 maintenance.

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We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

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(Additional Classified on pages 51 and 70)

Seymour S. Cohen, M.D. (r.), associate professor of physiological chemistry in pediatrics, University of Pennsylvania, Philadelphia, receives Mead Johnson first award for research in Pediatrics during recent convention of the American Academy of Pediatrics. Presenting the certificate is T. F. McNair Scott, M.D., research professor of pediatrics, University of Pennsylvania, and director of research, Children's Hospital, Philadelphia. In picture at right, Julius Hess, M.D. (l.), Michael Reese Hospital, Chicago, accepts Borden award for his work in the care of the premature. Henry G. Poncher, M.D., Chicago, makes the presentation.

istrator, Rumford (Me.) Community Hospital, is now administrator, Webber Hospital, Biddeford, Me. He succeeded **James V. Devine,** who became administrator, Wesson Maternity Hospital, Springfield, Mass. **Merrill E. Tolman** replaced Mr. Falvey at the Rumford Hospital, and **Garner C. Goodwin** succeeded Mr. Tolman as administrator, Waldo County General Hospital, Belfast, Me.

Nathaniel W. Faxon, M.D.—has been appointed consultant to the Danbury (Conn.) Hospital, to make a survey of the hospital's problems and policies.

Jerome M. Friederichs—is chief engineer, new St. Anthony Memorial Hospital, Effingham, Ill.

Frank C. Gabriel—named resident administrator, W. I. Cook Memorial Hospital, Fort Worth, Tex. Mr. Gabriel, past president of the Association of Western Hospitals, has been working in New Mexico, where he organized the New Mexico Hospital Association and the Blue Cross plan of New Mexico.

J. Francis Gallagher—has resigned as administrator, Community Hospital, Meyersdale, Pa.

Robert L. Gill—administrator, Altoona (Pa.) Hospital, for the last 12 years, has resigned. He will remain in his position until Mar. 15, or until a replacement is obtained.

Benjamin S. Gillespie, M.D.—has been appointed director, department of anesthesiology, Western Pennsylvania Hospital, Pittsburgh.

J. S. Grewal, M.D.—resigned as director, Kilmer Memorial Laboratory, which is associated with Binghamton (N. Y.) City Hospital.

Connie M. Guion, M.D.—recently became the first woman to be elected an honorary governor of the Society of the New York Hospital. Dr. Guion has been chief of the hospital's general medical clinic since 1932 and is professor emeritus of clinical medicine at Cornell University Medical College.

Samuel F. Haines, M.D.—has been elected chairman, board of governors, Mayo Clinic, Rochester, replacing **Arlie R. Barnes, M.D.,** whose resignation because of ill health was announced in the January issue. Dr. Haines has been vice-chairman of the board.

Lawrence W. Hart, M.D.—is medical director, Children's Mercy Hospital, Kansas City, Mo. Dr. Hart recently completed service as a captain in the Army Medical Corps.

J. Gus Henderson—is assistant administrator, City-County Hospital, Fort Worth, Tex. He was formerly finance officer, VA Hospital, Amarillo, Tex.

William R. Huff—has been appointed permanent executive secretary, West Virginia Hospital Association. His office will be in Charleston.

Mrs. Aileen Jeisy Johnson, R.N.—will be the new director of nurses and director of the school of nursing, Orange County (Calif.) General Hospital, succeeding **Mrs. Dorothy Kaladic, R.N.** Mrs. Johnson has held supervisory positions on staffs of hospitals in Illinois, Missouri, California, and Ohio. She received a master's degree in nursing education from Colorado State College, Greeley, and recently obtained a certificate in public health nursing from the University of Minnesota. Her predecessor, Mrs. Kaladic, is returning to Minneapolis, Minn.

Dale E. Keller—formerly business manager, Saunders County Community Hospital, Wahoo, Neb., is now assistant business manager, Children's Memorial Hospital, Omaha, Neb.

James V. Lappin—has become administrator, Stetson Hospital, Philadelphia, succeeding **Harvey B. Cope**. Mr. Lappin formerly was assistant administrator, Cooper Hospital, Camden, N. Y.

Ralph Linsey, M.D.—is administrator, Rockwall (Tex.) Medical and Surgical Clinic, which was opened on Dec. 1.

Eugene Lopez—has resigned as administrator, Paragould (Ark.) Community Hospital.

Edwin W. Miller—has been named administrator, Huron Road Hospital, East Cleveland, O., succeeding **Raymond G. Bodwell**, who has been relieved of his administrative duties so that he can devote full time to the hospital's building and modernization program. Mr. Miller formerly was assistant director, City Hospital, Akron, O.

William Nesbit, M.D.—is now medical officer in charge, U. S. Public Health Service Hospital, Seattle, Wash. He replaces **J. F. van Ackeren, M.D.**, whose appointment as chief medical officer, U. S. Coast Guard, was announced in the November issue.

Walter Noakes—formerly assistant manager, Mercy Hospital, Oklahoma City, is now manager, Wewoka (Okla.) Municipal Hospital.

Mattie B. Pangborn—retired Jan. 1 as administrator, Holden Hospital, Carbondale, Ill. Her successor is the **Rev. Clarence Marrill.**

Louis H. Pink—has retired as chairman of the board, Associated Hospital Service of New York. He will remain with the service in an advisory capacity. **Charles Garside**, who succeeded Mr. Pink as president of the organization in 1950, will serve also as chairman of the board.

Mrs. Josie M. Roberts—is retiring Feb. 1 as administrator, Methodist Hospital, Houston, Tex. She will be succeeded by **Ted Bowen**, assistant administrator at the hospital since 1948.

Arthur G. Rodgers, M.D.—has been named director, Binghamton (N. Y.) State Hospital, succeeding **Hugh S. Gregory, M.D.**, whose retirement was announced in the January issue. Dr. Rodgers had been assistant director, Central Islip State Hospital, since December, 1931.

Howard A. Rusk, M.D.—director, Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, has been named the 1952 winner of the Dr. C. C. Criss award of $10,000 and a gold medal, in recognition of his work in rehabilitating the physically handicapped. The award is given annually by Mutual of Omaha, for outstanding contributions in the fields of health and safety.

Floyd A. Sorensen—has been appointed assistant administrator, Salinas (Calif.) Valley Memorial Hospital. He served his administrative residency at the Herrick Memorial Hospital, Berkeley, Calif., and the Sequoia Hospital, Redwood City, Calif.

Harry W. Topolosky, M.D.—recently became medical director, Alum Crest Hospital, Columbus, O., succeeding **William F. Bradley, M.D.**, who resigned.

Alma M. Troxell—superintendent, Oil City (Pa.) Hospital, received the annual award of the local Exchange Club for outstanding contributions to the community.

Robert W. Wallace—is now administrator, Wood River (Ill.) Township Hospital. He succeeded **Stanley W. Martin**, who resigned. Mr. Wallace formerly was assistant administrator, Beyer Memorial Hospital, Ypsilanti, Mich. **Norton Hilton**, who resigned as business manager of the Wood River institution, will not be replaced, since the business manager's duties will be assumed by the administrator.

Harold Warren—formerly administrator, Hopkins County Memorial Hospital, Sulphur Springs, Tex., has accepted the position of administrator, Central Baptist Hospital, Lexington, Ky., which is scheduled to open in 1954.

Granger E. Westberg—has been appointed as the first full-time chaplain, University of Chicago Medical Center. He was formerly chaplain, Augustana Hospital, Chicago.

Ray Woodham—is now administrator, Presbyterian Hospital Center, Albuquerque, N. M. He formerly was assistant administrator, Baylor University Hospital, Dallas, Tex.

Ralph H. Young, M.D.—has succeeded the late **Louis T. Wright, M.D.**, as director of surgery, Harlem Hospital, New York City. **Solomon Weintraub, M.D.**, replaced Dr. Wright as head of the hospital's Cancer Research Foundation.

Deaths

Temple Adair, M.D.—70, founder, Oak Hill (W. Va.) Hospital, died Dec. 12 in Beckley, W. Va.

Milton L. Anfenger—78, president, National Jewish Hospital, Denver, Colo., died in Denver Dec. 9. He was in his seventh consecutive term as president of the free, nonsectarian tuberculosis center.

Richmond J. Beck, M.D.—chief of

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PERSONALLY SPEAKING continued

physical medicine, VA Hospital, Lyons, N. J., died in New York City Nov. 11.

Sister M. Louise Boyle—74, former superior, St. Joseph's Hospital, Pittsburgh, died Dec. 27.

Sister M. Claudia—82, former assistant superintendent, All Souls' Hospital, Morristown, N. J., died at the hospital Dec. 26.

Howard M. Cleveland, M.D.—68, chief surgeon and manager, Kane Summit Hospital, Kane, Pa., died Dec. 29 in Philadelphia.

Daniel T. Cole, M.D.—70, former assistant superintendent, Anna (Ill.) State Hospital, died Jan. 2 in Elgin, Ill.

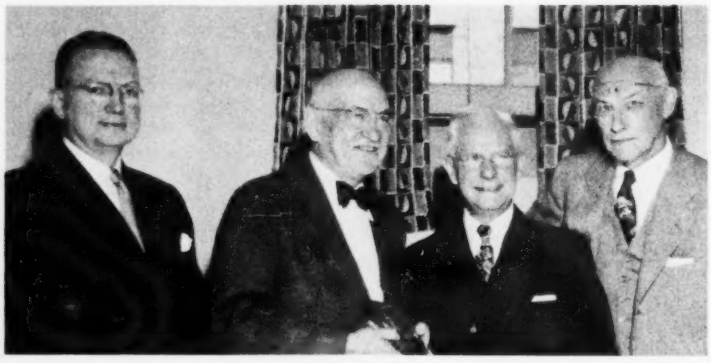
Arthur W. Erskine, M.D.—67, past president, Radiological Society of North America, died Dec. 10 at his home in Cedar Rapids, Ia.

Msgr. John Joseph Healy—49, vicar general and director of hospitals, Little Rock (Ark.) diocese, and past president, Catholic Hospital Association, died in Little Rock Dec. 6. A nationally known leader in Catholic hospital work, Monsignor Healy also was active in the American Hospital Association. He was a charter member of the house of delegates, was vice-president from 1941 to 1942, and had been on the board of trustees since 1948.

Gertrude L. Heatley, R.N.—administrator, South Side Hospital, Pittsburgh, since 1936, died Dec. 25 at the hospital. She had served three

OUR MISTAKE

In our January issue we unknowingly transposed these two photographs and consequently printed the wrong picture with the wrong caption. Here they are as we had originally intended.



George W. Bach (third from r.), president of the governing board, St. Vincent's Hospital, Erie, Pa., and former president, American Sterilizer Company, recently received the 1952 Benjamin Rush award from the Medical Society of the State of Pennsylvania.

The award is presented annually to a layman who has made outstanding contributions to the advancement of health in his community. Mr. Bach was selected by the Erie County Medical Society for the honor. Shown with him are (l. to r.): J. M. Walsh, M.D., president, Erie County Medical Society; A. H. Roth, M.D., chief of staff, St. Vincent's Hospital, and Elmer Hess, M.D., head of urology department, St. Vincent's Hospital.

Officers elected at the first annual clinical meeting of the American Academy of Obstetrics and Gynecology were (l. to r.): C. Paul Hodgkinson, M.D., Detroit, secretary; Herbert E. Schmitz, M.D., Chicago, treasurer (re-elected); Robert A. Kimbrough, Jr., M.D., Philadelphia, president; Howard Stearns, M.D., Portland, Ore., first vice-president (re-elected); and Charles D. Kimball, M.D., Seattle, assistant secretary. Not pictured are Bayard Carter, M.D., Durham, N. C., president-elect, and Joe Vincent Meigs, M.D., Boston, second vice-president. (See page 45—January issue.)

terms as president of the Pennsylvania State Nurses' Association.

Mortimer Herzberg, M.D.—73, former director, pathology laboratory, Jewish Hospital, Cincinnati, died Jan. 7 in Wilmington, N. C., where he had lived since his retirement 10 years ago.

Rev. Fr. Francis J. Kilpatrick—46, chaplain, Warner Brown Hospital, El Dorado, Ark., since 1948, died Dec. 24 at the hospital.

Mary Eliza Merritt, R.N.—superintendent of nurses, Red Cross Hospital, Louisville, Ky., for 34 years, until her retirement in 1945, died Jan. 8.

Christopher J. Mogan, M.D.—50, assistant chief, outpatient department, Kennedy VA Hospital, Memphis, Tenn., died Dec. 23 in Memphis.

Alfred Lee Morris, M.D.—83, former acting superintendent, Spencer (W. Va.) State Hospital, died in Charleston, W. Va., Dec. 29.

Edwin C. Schmidtke, M.D.—52, former chief of staff, University and Boone County Hospitals, Columbia, Mo., died Dec. 27 in Columbia.

W. D. Schwartz, M.D.—82, first surgeon to perform a double tonsillectomy with local anesthesia, died in Portland, Ind., Dec. 28. The operation was performed at St. Bartholomew Hospital, London, England, in 1900.

Frank J. Tainter, M.D.—79, former chief of staff, St. Anthony's Hospital, St. Louis, died in St. Louis Jan. 1.

Lewis Hill Weed, M.D.—66, nationally known anatomist, died at his home in Reading, Pa., Dec. 21. He was director, Johns Hopkins University School of Medicine, from 1929 to 1946.

VA Appoints Four Hospital Heads

Appointment of four new managers for VA hospitals has been announced by the VA.

Peter J. Volpe, M.D., formerly manager, VA Hospital, Aspinwall, Pa., succeeds **Kelso A. Carroll, M.D.**, as manager, VA Hospital, Hines, Ill. Dr. Carroll's transfer to the VA central office, Washington, D. C., as assistant chief medical director for professional services, was announced last month.

New manager of the VA Center, Kecoughtan, Va., is **Reuben Cohen**, formerly assistant manager, VA Hospital, Brooklyn. Mr. Cohen replaces **Philip L. Collins**, who was transferred as manager to the VA Hospital, Oteen, N. C.

Ezra R. Bridge, M.D., is manager, VA Hospital, Batavia, N. Y., succeed-

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ing the late **Charles F. Sargent**, and **John R. Prusmack, M.D.**, replaces **Albert W. Waldron** as manager, VA Hospital, Palo Alto, Calif. Mr. Waldron is retiring.

Both Dr. Bridge and Dr. Prusmack had been serving as chief of professional services in the hospitals they now manage.

Ross Succeeds Kimbrough on VA Advisory Group

Robert A. Ross, M.D., Durham, N. C., has been appointed to the VA's special medical advisory group, it was announced by Vice Adm. Joel T. Boone, chief medical director, VA.

Dr. Ross, professor and head of the department of obstetrics and gynecology, University of North Carolina, replaces **Robert A. Kimbrough, Jr., M.D.**, Philadelphia, who resigned because of the pressure of other duties.

Dr. Freer Receives VA's Highest Honor

Arden Freer, M.D., who retired Dec. 20 as deputy chief medical director, VA, received the VA's highest award, the exceptional service medal.

The citation, the fourth such award to be presented by the VA, was given to Dr. Freer at a ceremony attended by the 20 members of the VA's special medical advisory group and staff officials. Dr. Freer was praised in the citation for his "outstanding leadership, judgment, and advice."

Nurse Transfers Announced

Martha M. Havlik, R.N.—formerly acting assistant chief, nursing service, VA Hospital, Grand Island, Neb., is now assistant chief.

Esther W. Jencks, R.N.—now is assistant chief, nursing service, VA Hospital, Providence, R. I. Before her transfer, she was a supervisor, VA Hospital, Boston.

Madeline A. Kennedy, R.N.—is assistant chief, nursing education, at the Boston hospital. She was formerly assistant professor of nursing, Boston University School of Nursing.

Aurelia B. Killian, R.N.—has retired as assistant chief, nursing service, VA Hospital, Tomah, Wis. Her first VA appointment was at Chicago.

Dr. Corwin Retires From Academy Post

Edward H. L. Corwin, Ph.D., has retired as executive secretary, committee on public health relations, New York Academy of Medicine, after 41 years in that position.

More than 100 persons attended a dinner which the committee gave in his honor on Dec. 10. A portrait of Dr. Corwin has been commissioned by the Academy and is being painted by Vittorio Borriello.

Dr. Corwin began a new job on Jan. 1 — that of consultant to the committee on public health, Medical Society of the County of New York.

Author of numerous articles and several books on hospitals, including "The American Hospital," Dr. Corwin also was a co-founder of the first International Hospital Association, organized in 1929.

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Behind the Scenes in the

Sterile Supply Room

● An important and extremely busy department of Columbia-Presbyterian Medical Center, New York City, is the Sterile Supply Room. In this small section of the Medical Center lies the responsibility for the preparation and delivery of almost all the sterile items used throughout the Center, for the sterilizing of some solutions for pharmacy, and for the sterilization of sets packed by other services.

Under supervision of administrative assistant, Dale K. Tuller, is a staff of 20 employees and 14 volunteers. All employees in Sterile Supply are trained in several jobs so that workers can be shifted when the work load becomes heavy in one area.

About 12,500 intravenous and intramuscular needles are processed each week in Sterile Supply. Needles are soaked for 24 hours, inspected for hooks, burrs, or dull points, cleaned by automatic washer, styletted, and finally sterilized.

Another big job is the processing of an average of 1,100 gloves each day. Gloves are washed and then tested for holes. After they are sorted into sizes, gloves are powdered and sterilized.

After the final step has been taken in the preparation of all supplies (sterilization), they are ready for redistribution.

Here and on the following two pages are pictured the tasks performed in the Sterile Supply.

Above left: A big job in Sterile Supply is folding linens for operating room drums. Linens are washed in the laundry then sent to Sterile Supply to be packed and sterilized.

Above right: Two volunteers work with packing drums. Some 400 drums are packed and sterilized every day and sent to an average of 88 points throughout the Medical Center.

Left: Sterile Supply manufactures or modifies 57 different items, mostly dressings, used by special units. Preparing some of these items are three regular volunteers.

Photographs by Manny Warman

Adapted from a picture story which appeared in THE STETHOSCOPE, house organ of the Columbia-Presbyterian Medical Center, New York City, by permission.

Above: Needles are inspected for hooks, burrs, or dull points.

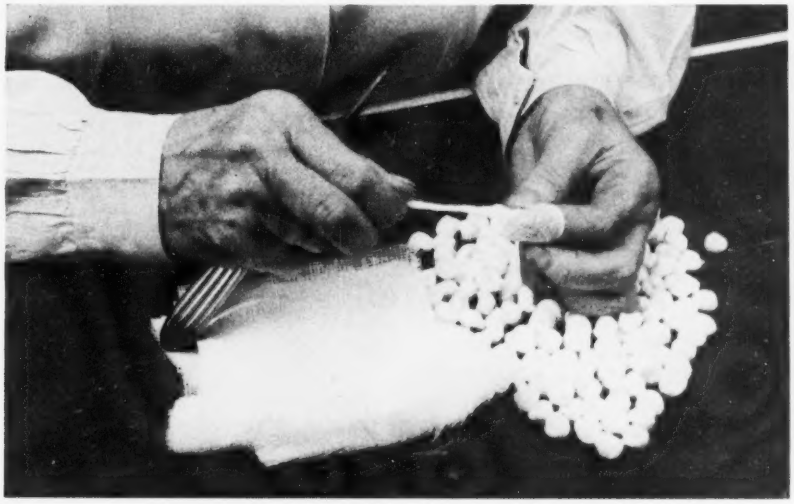
Above: Gloves are tested for holes by squeezing air out of them.

Above: All needles are styletted to clear them of obstruction.

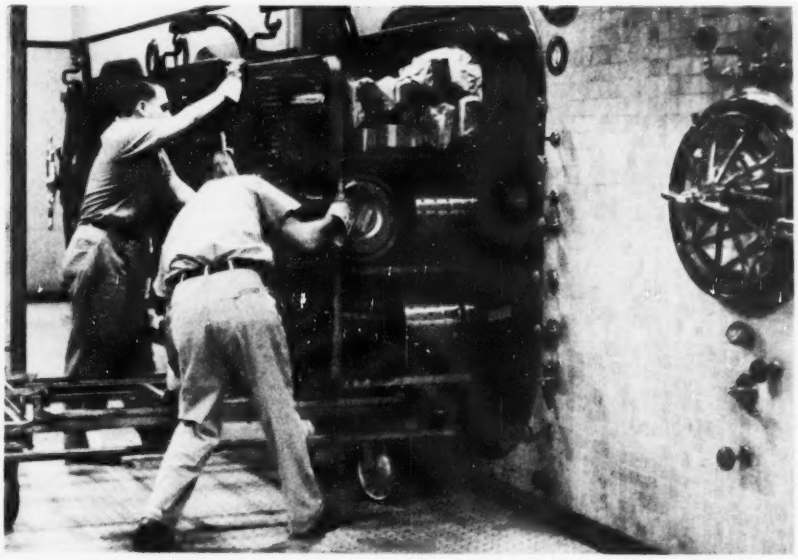
Below: A general view of the Sterile Supply workroom.

Above: Sterile Supply is responsible for the preparation of all medicated ointments and gauzes used in the Center.

Below: One of the special items prepared is the "peanut sponge" which is not manufactured commercially. The sponges are made by twisting strips of gauze into balls.



Below: Final step in preparation is sterilization. Here the autoclave, loaded with supplies, is readied for the sterilization period.



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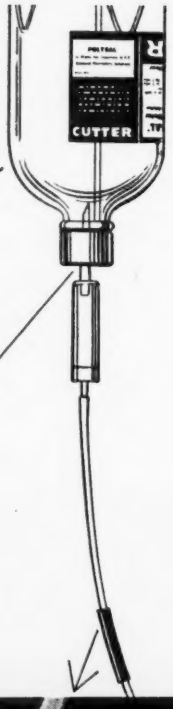

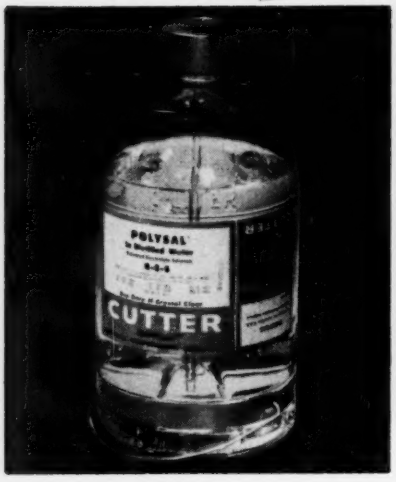

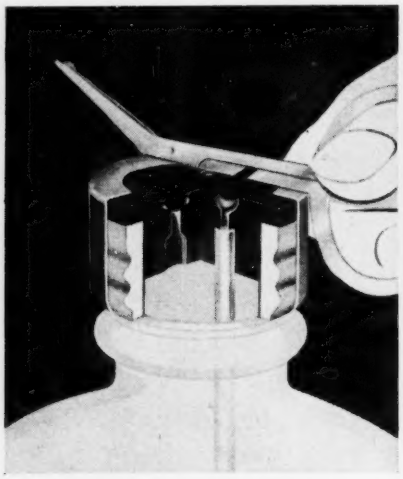

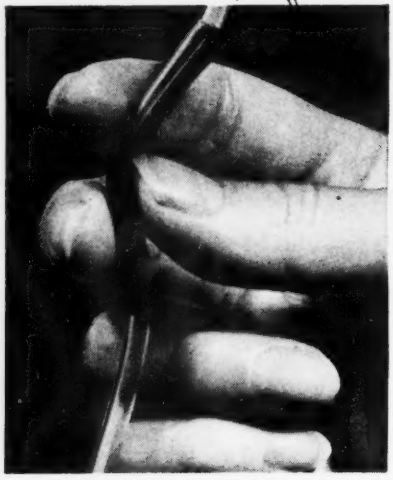

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Methods of Sterilization*

By Carl W. Walter, M.D.
Surgeon, Peter Bent Brigham Hospital
Boston, Mass.

Left: Dr. Walter explains the method of using an instrument washer to Edythe Angell, ORS, (l.) and Eleanor Marobella, assistant ORS, both of University Hospitals, Cleveland. The photograph was taken during Dr. Walter's course in aseptic technic given in Cleveland last November.

• I welcome the opportunity to speak to operating room nursing groups, largely because I can remember the days when it was a triumph to get any two operating room nurses from any two hospitals in the same city together, and it has been very stimulating to watch this group grow and to see benefits come to patients, to the profession and to hospitals, simply because you have an opportunity to meet and exchange ideas and are beginning to realize that you are an important part of patient care.

As you go on and grow and assume more responsibility and help to pattern thought in the field, patients will benefit more and more.

I shall try to illustrate that during the talk.

I have been a little puzzled as to how to talk about sterilization in an hour, when it really takes several days to cover the subject adequately. However, I thought that we might sort out some of our ideas on the subject by a brief review of the various types of sterilization available, trying to point out the pitfalls and trying to show you why hospitals can sit and dream of high voltage equipment and cosmic ray or electronic sterilization, and may feel very modern, but the real task, as far as applying sterilization in hospitals is concerned, is going to be to understand the simple things, like steam and boiling water, which can be used every day at a minimum expense and which really do the job well and very simply, without introducing heavy expenses for capital equipment and heavy charges for maintenance and without making the sterilizing process a real technical feat, rather than an ordinary, every-day accomplishment.

I mention this largely because at the International College of Surgeons' meeting in Chicago, where I spoke before the Operating Room Nurses' Association, there were several discussants on the floor who kept saying that problems of sterilization would all be solved with electronic sterilization. Everybody had an idea that this was right around the corner.

One of our big problems, however, is learning how to use boiling water, so that patients will be safer and less money will be spent in the process.

There are several ways of destroying organisms, and, strangely enough, they all involve the same, basic prob-

* *Paper presented at the two-day institute on operating room administration and nursing sponsored by the Massachusetts Organization of Operating Room Nurses, Unit I. (See December issue.)*

Above: Attending Dr. Walter's course in Cleveland were, l. to r.: Ethel Platt, CSR headnurse; Ethel Clark, OR instructor; and Edith Jones, assistant ORS. All the nurses are from Mt. Sinai Hospital, Cleveland.

METHODS OF STERILIZATION continued

lem. The first one which you all use is chemicals. The big problem with chemical disinfection is to get a toxic chemical in contact with all the bacteria. This problem is complicated by the fact that bacteria usually grow in some sort of culture medium; this culture medium coats the bacteria, and prevents adequate contact beween the organism itself and the chemical which you use in the attempt to destroy it.

Other things, such as grease, finger prints and oil on the skin, render the bacteria more or less waterproof, and chemicals do not contact the bacteria at all.

So we have the problem of getting good control of the interfaces, between the organism and the chemical. It is a matter of cleanliness, being certain that the germicide is exhibited to the organism in the optimum quantity and long enough to destroy the organism.

Unfortunately, things are not quite that simple, because some organisms produce spores, which are much more resistant to chemical effect. The viruses are not affected by chemicals at all.

Whenever you use a chemical, remember that there are none known to date which destroy bacterial life reliably each time. Even 100 percent at any exposure with all of them, if used even under optimum circumstances, certain organisms will survive, and we either do not know how to culture them or we do not culture them long enough.

In most clinical situations, this is of little importance. But, in others, it is of great significance. For example, the virus of homologous serum jaundice will survive contact with all known chemicals and will perpetuate the disease in a human being, even when you have minute inoculations of that organism.

So that for patient care, the chemical disinfection of instruments, needles, syringes and that sort of equipment is quite impossible if you want to prevent widespread epidemics of homologous serum jaundice.

Therefore, the use of chemicals in becoming more and more limited to a field where heat cannot be used. Disinfection of the skin, for example, is one situation where it is the best technic available.

Now, there are many who think of carboxide gas, which is ethylene oxide, as a method of chemical sterilization. Indeed, that is true, but again, it does not destroy one hundred percent of the organisms, and, as ordinary hospital supplies are made up and handled, it isn't a reliable or thoroughly feasible method of sterilization.

The other method is physical destruction of bacteria, and we can go on and mention a great many of them. There is the cosmic ray, ultra-violet, etc. They are all expensive and difficult to use. The easiest and the most applicable one is heat.

TWO FORMS OF HEAT

We have two forms of heat to consider in sterilization. One is dry heat, and the other is moist heat. Dry heat is advantageous for many reasons, one being that it does not destroy finely polished edges, so that cutting edge instruments, such as scissors, osteotomes, etc., are best sterilized in dry heat; and, it does not attack glass.

As for syringes, grinding removes the annealed protective film, and makes the surface subject to attack by moisture, whereas you can sterilize them repeatedly in dry heat, without wear and tear. If you use moist heat, the silicon is leached out, and the syringe leaks.

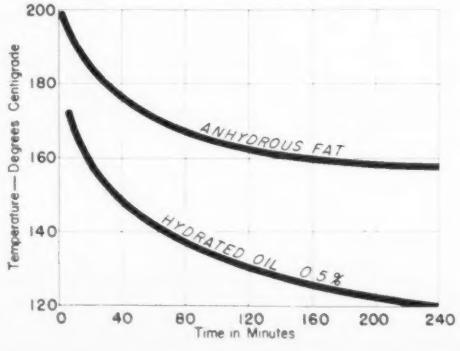
The other reason dry heat is good stems from the fact that the temperature developed is hot enough to destroy bacterial life of itself, so that you don't have to worry about grease, protein, etc., interfering with sterilization.

Accordingly, knife blades, with finger prints on them, and scissors, with grease on them, can be sterilized by adequate exposure to dry heat.

There are two temperatures which are used (Figure 1):

Figure 1

THERMAL DEATH TIME OF SPORES IN DRY HEAT



121 degrees centigrade (250° F.), for four hours, is one period, which is thoroughly safe; another is 160 degrees centigrade (320° F.) for one hour. That will give you some concept as to the time required. This is the actual temperature of the instrument you wish to sterilize. It may take a half hour to an hour and a half to heat the sterilizer from room temperature to sterilizing temperature, and once you get it there, it takes an hour at 160° C. to sterilize, and one to one and a half hours for the sterilizer to cool so that the instruments are safe to handle.

It is important to remember that an instrument at 160° C. (320° F.) is hot enough to give you a severe burn, if you happen to touch it with your fingers.

Most dry heat sterilizers work best if you load them at night, and have the sterilizing cycle go on, overnight, and then your instruments are ready for use the first thing in the morning.

When sterilizing syringes, the clean plungers and barrels are assembled, and a little plastic tip is put on the end of the syringe. You can load several thousand syringes in the steam sterilizer; turn the heat into the jacket, and close the door. You do not turn the heat into the chamber and you just leave them there all night. By the time you come back in the morning, that load will have heated to 121 degrees C. (250° F.), the heat being supplied by the steam in the jacket, and you will have left it there four or more hours at 121 degrees C. (250° F.), and when you unload the sterilizer, you have thousands of clean, dry, sterile syringes, ready for use.

The same sterilizing technic can be used for surgical instruments.

ACCURATE CONTROL

The big problem is accurate control of temperature and accurate timing so that you get exposure adequate to destroy the bacteria.

Moist heat presents several problems which we should discuss. We can choose various degrees of temperature, depending upon how much time we have available to do the task at hand. If you take a high temperature, such as 130° C. (270° F.), the bacterial thermal death time drops to a point where it takes less than two minutes to destroy the most difficult resistant spore that you can produce. Hence, you have a good means of emergency sterilization of instruments in steam, 130 degrees C., 2[illegible] pounds pressure. (Figure 2)

That degree of heat is too severe for rubber goods, and it is destructive of textiles, so that we like to use lower temperatures for this type of supply. We choose 121 degrees C. (250° F.) for more routine sterilization, where time is not an important factor.

Here, we have a thermal death time of 13 minutes, for contact between the steam and the bacteria, so that we can be sure of destruction of bacteria. (Figure 3)

Then, in many hospitals, where you do not have steam sterilization you must rely on boiling water, which at sea level is 100 degrees C. (212 ° F.); unfortunately, that is not a sufficiently high temperature to destroy dry resistant spores or to destroy bacteria, protected by the grease and oil which surround most bacteria in hospital practice.

THREE LEVELS OF MOIST HEAT

We have, then, these three levels of moist heat that we can consider here. 130° C. (270° F.) for speed; 121° C. (250° F.) for practicability; and 100° C. (212° F.) for sanitization. There, you have it, 130° C., 121° C., and 100° C.

We have the same problem of making certain that the steam contacts the least accessible spore on the article you wish to disinfect that we have with chemical disinfection. Here, we must recognize that the same principles which interfere with chemicals, also interfere with the action of moist heat. For example, a layer of grease or oil on the outside of a spore or a bacterial culture will delay the lethal effect of that heat for many hours. Therefore, if you package your bacteria in an insulating package, so that the moist heat cannot penetrate to the depth of the package, you should not be surprised to find that the bacteria survive exposure to the steam.

We are not talking about exposure of the package to steam; we are talking about exposure of the bacteria in the center of the package, the least accessible portion of the package to steam.

So that you can immediately see that we have three problems. One is the problem of destroying the bacteria on a clean, dry instrument, where essentially there is surface contact, as contrasted with the problem of sterilizing

Figure 2

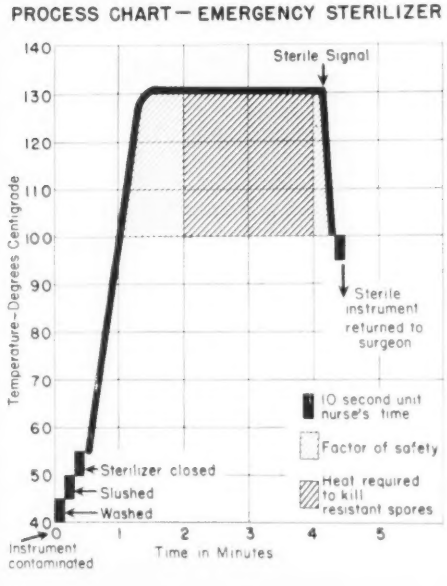
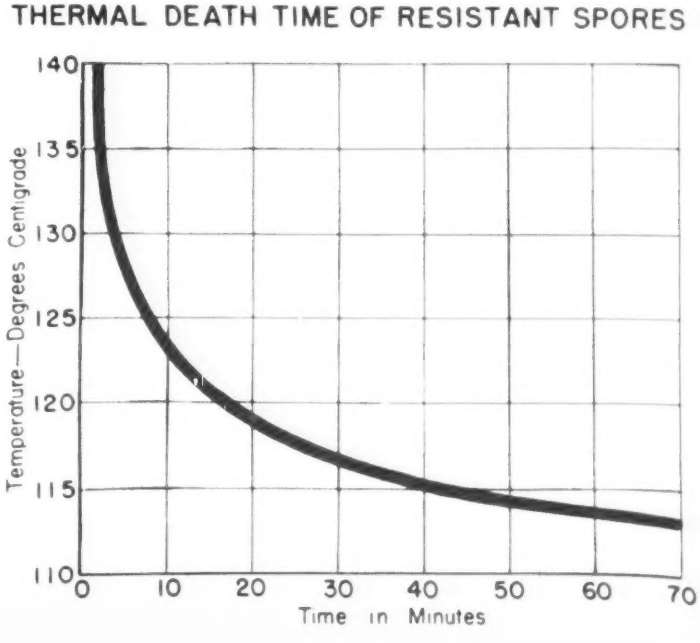


Figure 3



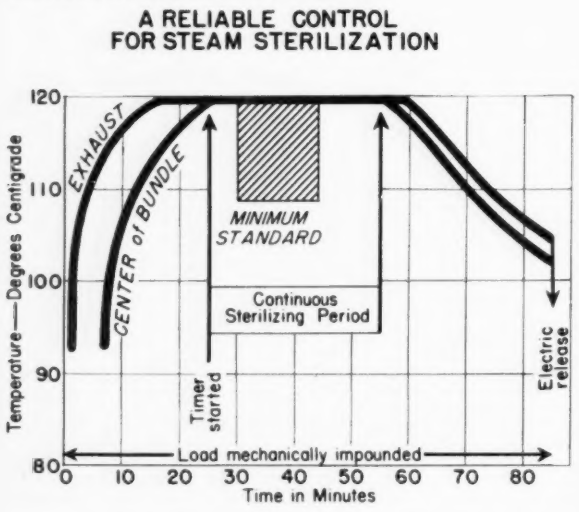


Figure 4

the bacteria, extended in a litre of water, where your big problem is to heat the whole flask of solution to sterilizing temperature first, before you can depend upon that temperature to destroy the bacteria, or, a third problem, that of heating the entire package of textiles, which you call a laparotomy kit, to 121° C., so that the least accessible spore in the center of that package will be at 121° C., and you can begin to time your thermal death time accurately.

You can see the limiting factor in all of these circumstances is the largest package or flask you have in your sterilizer.

You then make the decision in timing; whether you are going to have a very complicated system in your sterilizing room, of dividing all the packages into lots of small ones, little ones, big ones, or whether you are going to be more or less standard about it and choose a period safe under all conditions, no matter how large the package is, and thus sterilize large packages along with a lot of little ones, which could have been done in less time; but, for the sake of standardization and for the sake of convenience, are loaded in the sterilizers and done all in a uniform period of time.

When it comes to flasks of solutions or bundles of textiles, the simple practice is to adopt a standard period for sterilization, such as thirty minutes, after the exhaust line temperature gets up to 121° C. (250° F.) (Figure 4)

For surface sterilization, such as with instruments, your problem is a little simpler. The problem is only on the surface of the instruments, and you can save a great deal of time using 121° C. for 15 minutes. For emergency sterilization, three minutes at 132° C. will be adequate to sterilize a clean, grease-free instrument.

The various factors which enter into the consideration of timing, I don't think are worth discussing here, if you will concede that the most important thing that you must know in a sterilizing room is that all the material has been adequately exposed, and that everything that comes out of the sterilizer is sterile. That focuses your attention immediately on the largest flask, and on the largest kit, and you make sure that that is packaged properly, and that it is sterilized properly, and you can be equally certain that all the other materials in the sterilizer are also sterile, whereas if you allow the operators some latitude to judge the timing on each load, you are quite likely to run into the circumstance where the occasional large package gets by or where large flasks get timed for the same period of time that the small ones have, and you come up with a disaster for some patient.

The only excuse for cutting time is to increase the capacity of small sterilizers; that is, the daily output of small sterilizers, or to protect textiles or solutions from destructive action and heat. The latter is not a factor because the destructive effect of steam exerts itself during the initial heating to the sterilizing temperatures, and once you get it to that temperature, 121° C., steam is not destructive to any of the solutions used in hospital practice, which can be sterilized, or to any of the textiles.

It is the heating and the cooling which do the damage, so you can keep it at the temperature you want, as long as you wish, and if the solutions are made up properly, and if the packages are properly wrapped, you will not get into difficulty.

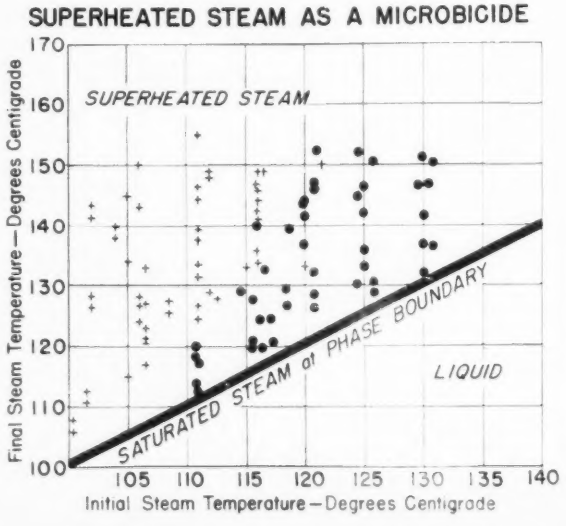
Now, to time a package of textiles presents, I suppose, the best example of the problem, in running your steam sterilizer. First of all, you have to provide enough steam to penetrate the complete package. When it penetrates the complete package, there are several things that steam must do. The first thing it does is to satisfy the thirst of the textile fiber for moisture. Textile fibers take in a great deal of moisture, to keep themselves in equilibrium with the relative humidity of the air.

During August, and the summer months, the amount of moisture is very great, and you have saturated textiles. Any of you who live in this part of the country are certainly familiar with the fact that you go to bed on a humid night and the sheets feel clammy and wet and don't seem to have any power of absorbing any more moisture. They are one hundred percent saturated, and will weigh twenty percent more in August than they do in December, when they dry out, due to the fact that the relative humidity of the air in the steam-heated room is very low.

So that if you put sheets into a sterilizer in August, the only temperature energy which is expended is that necessary to heat the sheet from room temperature to sterilizing temperature. Once it is heated, you then begin to time the period for the destruction of bacterial life.

If you take this sheet and try to sterilize it in December, when it is dry, then the energy exchange is determined by the amount of water which is absorbed into the textile fiber, during the process of heating, and you will find that the energy is greatly in excess of that necessary

Figure 5



to heat the textile from room temperature to sterilizing temperature, and you have, in the process of supplying moisture to that package, a great deal of extra energy, which goes to heating the package, and these temperatures will often get sufficiently high to actually char the textile, and you see chocolate brown or burned-looking or burned-smelling textiles come out of the sterilizers, where the maximum temperature was only 121° C.

This presents us with one of the problems of steam sterilization—to be sure we are using the temperature we think we are using. We do this by making certain that the textiles are saturated with moisture, when going into the sterilizer. In the summer months, it presents no problem; nature does it for us.

As soon as steam heat is used in the hospital, we have to think about the state of hydration of textile fibers, and this involves taking them directly from the laundry and sterilizing them before they can dry out, or it means spraying them with a spray of distilled water, to hydrate them, before putting them into the sterilizer. This is important because super-heated steam is not a good sterilizing agent. It is essentially dry heat. If you take steam at 121 degrees, and apply 40 degrees of super-heat to it, you get 161 degrees. You take ordinary moist heat, and you add extra energy to it, and you have dry heat, which is effective the range of an hour exposure, rather than in the shorter period we like to use.

The other important fact, of course, is that as far as rubber goods and textiles are concerned, the super-heat destroys the textiles and rubber goods.

The culture which you put into steam at 121 degrees for 13 minutes will come out sterile; in super-heated steam at 161 degrees, the same culture will come out unsterile.

You can easily see that from this slide (Figure 5), which shows you the difficulty with super-heated steam. The slide is simply a thermal death time, a curve where we start with steam, for example, at 121 degrees.

With the ordinary steam in a steam sterilizer, we add to that extra energy which in this case is furnished by the energy liberated as textiles are hydrated. You can see that at 121° C. the steam will give you negative cultures. As you add 10 or 15 degrees of super-heat, you soon get to the stage where you find positive cultures. You begin to get those which are troublesome.

Now, in a hospital package, the super-heating is more severe on the outside, largely because that is where the energy exchange occurs. You have the paradoxical situation that it is quite possible to get a laparotomy kit sterile in the middle because the moist steam actually develops in the middle of the package, whereas the periphery of the package may not be sterile.

CONTROL AMOUNT OR MOISTURE

One thing to control in moist heat, and I am talking about textiles now, is the amount of moisture present when those textiles are placed in the sterilizer. In the winter months in a steam-heated room, saturate them with moisture before putting them in the steam sterilizer, first, to get them sterile, secondly, to be sure you do not destroy the textiles needlessly, during the sterilizing period.

Another thing to do is to be sure the packages are wrapped and packaged so that steam can get to the center of the package in the time which you wish to employ.

If you take a period of thirty minutes as your standard, then you have got to know how long it takes for steam to penetrate to the center of the largest package, in order to be sure that the least accessible spore will be exposed to saturated steam for an adequate time.

There are several ways of accomplishing that. The easy way, I think, is to imitate a standard package which

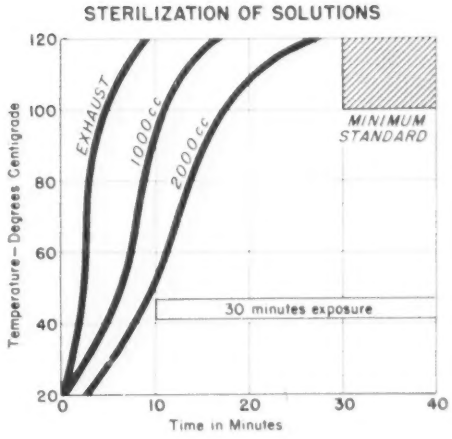


Figure 6

has been developed for this purpose. If you prefer you can study your own packages, and your own arrangements. There are many pitfalls in the method, and it is tedious, and when you come out with the answer, it is not likely to be much different than the type of answer which others have gotten, working in the field.

PACKAGE MUST ALWAYS BE THE SAME

The thing to consider when you develop a package technic are roughly as follows:

You have got to be sure that the internal arrangement of the package is always the same. You have got to recognize the fact that the package has got to be made up in a perfectly standard manner, size and shape, so that when it is loaded into the sterilizer, the penetration time will always be the same.

In thinking about that, we arrived at a standard size and shape, which fit the sterilizer carriage best. We tried to get the package arranged so that it would contain all the supplies for a standard, major surgical procedure.

This was hard to standardize, for size and shape, until we developed a wooden trough, which gave us length, depth and breadth, and a routine size for a standard package.

The internal arrangement is such that the largest sheet is rolled to give us an accurate division of the big package into four smaller ones, and we, by experimentation, then determined that it takes around 12 to 13 minutes for the center of the package to get heated to 121 degrees. Knowing that, you then give it 13 minutes for the thermal death time, and you have conditions which are fairly standard and can be relied upon to give you sterile textiles.

The question then arises, where do you measure the temperature for this type of device?

You can measure it with a thermocouple in the center of the package; but, that is expensive and difficult to do. It is much easier to measure the temperature of the steam being used in the sterilizer and then rely upon the experimental knowledge that if you use that kind of steam, your package will be heated in a certain period, and will be sterile thereafter.

You will, finally, rely upon a chart such as Figure 4, where you take the temperature in the exhaust line of the sterilizer; when it reaches 121 degrees C., you know from experiments that the center of the bundle is also getting hot; in 15 minutes after the exhaust line temperature reaches 121° C., the center of the bundle is 121° C. Then, you have this minimum standard of 13 minutes thermal death time, and the whole, continuous, sterilizing

period can be standardized, with 30 minutes for accomplishing this end.

I think that that is a simple, easy way of accomplishing the result.

The only way that you can get into trouble, from the point of view of the patient, is to change the internal arrangement of the package, so that this time-temperature relationship no longer pertains.

Now, from the point of view of sterilizing solutions, we have a little more difficult problem, in that we have to allow time for the energy to be exchanged across the surface of the flask in which you have the solution. The steam heats the glass; the energy has to go through the glass, and heat the solution inside the glass. This varies with the thickness of the glass, and with the kind of solution that you have.

This same chart which you saw before, now looks like this. (Figure 6). The exhaust line is 121 degrees. You can see that a 1,000 cc. flask takes 10 minutes; 2000 cc., 30 minutes. That is determined before you apply the minimum standards.

Now, a small flask of 50 cc. would heat much more quickly.

Then, too, you would have to have a longer standard period for a bigger flask. A very thin-walled flask, of 2000 cc., would come up in the neighborhood of 10 minutes, whereas a thick-flask would come to temperature in 20 minutes. And so the container has something to do with the rate at which the solutions come to temperature.

You have a set of problems, with the flask of solution, or any kind of liquid, which does not exist in the dry materials, because you have fluid at 250 degrees in equilibrium with steam at 15 pounds pressure. You wish to take it out of the sterilizer. You first have got to get rid of the steam pressure, so that the sterilizer can be opened. If the pressure is vented the solution at 250 degrees will boil, until enough steam has been given off to cool the solutions to 212 degrees.

COOLING THE STERILIZER

In the sterilizer, we accomplish the cooling by turning off the steam supply to the sterilizer, and permitting the whole sterilizer to cool down to 212 degrees, where a liquid will then be in equilibrium, with atmospheric pressures.

If you vent the steam from the sterilizer, your solutions will boil vigorously or they will splatter the contents of the flask out into the sterilizer, or may concentrate to the point where they are no longer useful as accurate solutions.

So that sterilizing solutions differ from textiles in that the end of the cycle must be managed very carefully.

When it comes to instruments, we have other factors introduced with reference to the steam sterilizer. We have tried to figure out exactly what is the heating time. One factor is the grease contamination on the instruments, which prevents moisture from getting to the bacteria, to make the degree of heat which is used effectively in the short period at your disposal.

This comes down to recognition of the hazard and trying to keep grease and oil out of the sterilizer. Instruments which are sterilized in steam must be protected from all contacts with grease and oil, and must be cleaned mechanically to be sure that they are free of oil and grease, each time they are used.

When you consider methods of cleaning instruments, I would invite you to look at the ordinary Charlab, a device developed for washing laboratory glassware, in bulk, and in which you can put an accumulation of the morning's instruments, and run them for an hour with a detergent, getting them free from oil and grease. Then, you can expose them to dry heat to dry the joints and locks thoroughly and store the instruments without the need of oil or grease to protect them from corrosion. In this way, you can sterilize instruments in the steam sterilizer with reasonable safety.

The other problem with instrument sterilization is to be sure that steam can contact every surface, and that there are no air pockets in which bacteria escape contact with steam.

STERILIZATION OF RUBBER

Two big problems here are the rubber tube and the ordinary rubber bulb. For example, the syringe bulb. If you just pick it off the shelf and put it in the sterilizer, the steam never gets inside because the air remains there. Or, take a long coil of rubber tubing; the air in the tubing is not purged from the lumen during steam sterilization, and the contents of the lumen go unsterile.

The way to avoid this is to rinse out the lumen of the tubing, or actually aspirate water into an Asepto syringe bulb, and flush it out; the film of water in that bulb or tubing is sufficient in quantity so that when the steam heats the rubber, the water will turn to steam and the steam will purge the air.

It takes very little water inside the lumen of a tube, or inside the hole or the hollow of a syringe bulb to purge the air. There is an enormous increase in volume, driving the air out of the channels, and permitting actual contact between the bacteria, and the steam, which is formed inside the tubing, and inside the rubber bulb.

Many folks forget that we are interested in the insides of these things. I saw a nurse the other day take a coil of tubing, hold it under the faucet and then put it into the steam sterilizer; she went through the motions, but she did not bring the patient the safety she should have. Water which should have been inside was on the outside, where it was not needed because as steam contacts a cold object, it condenses and furnishes its own moisture. But by the time it would reach the inside of the tubing, the tubing is hot; and no condensation forms. You then have inside the tubing a dry-heat sterilizer, where it takes four hours to do the work you can do safely in 13 minutes, if you have moisture present.

Remember, then, that in the sterilization of instruments, we have problems of grease, oil, and air-pockets.

To get things done more speedily, we raise the temperature, and this technic is best for emergency sterilization of instruments, where you want to sterilize extra instruments, or where unexpected pathology has been found. A three minute period at 131° C. is adequate for this purpose. (Figure 2)

The limiting factor in most hospitals for satisfactory use of equipment for this purpose is the fact that the steam supply is inadequate, and hence, you do not get prompt and really efficient emergency sterilization.

Because emergencies occur repeatedly, an emergency sterilizer should be a small one, so that it is not useful for other things. You can gear your technic to small kits of instruments, realizing that you can get additional ones to the field quickly. For example, a bone plate that somebody has carefully prepared at the last minute pops out on the floor; you can wash it, remove the grease from it in a fat solvent, put it in a sterilizer, and, with an adequate steam supply, you can get it back to the surgeon in four and a half minutes, absolutely sterile.

The fact that you have this kind of sterilizer in the

sterilizing room allows you great latitude in the selection of instrument kits. With basic kits, and with an alert person, you can keep ahead of the surgeon's needs, as long as you have five minutes' time. But, it is difficult if you have to wait a half an hour, or even fifteen minutes, for an ordinary low pressure or 250-degree F. steam sterilizer.

How does all this compare time-wise?

With the chemicals, exposure, with the best chemicals we can devise, is three hours. For boiling water, it is 30 minutes at 121° C. (250° F.)

You can see that there is an advantage in using steam, whenver you can, and when you can't use steam, you may resort to the use of dry heat—160° C. (320° F.) for 1 hour or 121° C. (250° F.) for 4 hours.

This, to me, is about as much of a thumb-nail sketch of sterilization and its problems as you see them in the operating room, that can be turned out in the brief time, here, without being bogged down with details, and I think that it ought to serve as a springboard for a series of questions, so that I may answer some of your problems regarding sterilization. Therefore, I would propose expanding the rest of my allotted time answering questions.

QUESTION PERIOD

Chairman Nichols: I have three written out for the problem clinic this afternoon.

Can silicon be used safely and effectively in lubricating joint instruments and the like?

Dr. Walter: Silicon can be used to protect the instruments from a certain amount of corrosion, and will make them work easily. There is no bacteriology to show that it is any different from oil, and it will, theoretically, protect bacteria. I cannot see that it offers any advantage over just plain clean instruments for this purpose. Although I will admit I have not studied the bacteriology of silicons in a steam sterilizer, they are film formers, and they protect instruments from corrosion because they prevent the steam from getting at the steel.

Question: Have you done any experimentation with Patapar paper, and if so, what, and your reactions to it?

Dr. Walter: I have done only preliminary experiments, and my feeling at this time is that it is too waterproof to be used in reliable sterilization. That is, if you are interested in getting a package done quickly and reliably, this paper is a bacterial barrier; it keeps air in and steam out, unless you use it for prolonged periods, in which case you are using dry heat sterilization.

If you use moist sponges, with moist bacteria on them to test, you get good bacteriological results, because the moisture is supplied by the package itself.

But, that is something that you cannot rely upon in the winter months, in a sterilizing room. The problem of running this down and doing the bacteriology is rather an expensive one, and no one to my knowledge has conclusive results.

The bacteriology has been studied in the Meinecke-Dennison double crepe paper, and one layer of that paper is the equivalent of ordinary muslin. But, no one has ever studied the economics of the situation to know whether papers cost more than properly used muslin.

Question: What is your opinion of Week cellophane sticks for preparing penrose tubing and catheters, for use as opposed to a formalin cabinet?

Dr. Walter: Cabinets are useless. They destroy nothing. The catheters are just as contaminated when they come out as they were when they went in. If they went in nice and clean and washed free of bacteria, they come out that way.

A formalin gas is a dry formalin gas; it just irritates your mucous membranes and makes you feel as though you had done something.

If you put them in a cellophane tube, with one end sealed with a clip, and sterilize them in saturated steam for 30 minutes at 250° F., that is a perfectly satisfactory and safeway of handling them. It is a useful technic. I have not had good luck sterilizing them with both ends of the tube sealed.

The way to do it easily is to break your paper or your guide or the package at the end, which is supposed to be opened, fold it up and seal it with a clip, and leave the opposite end opened for quick exchange of air and steam. You have got to have moisture inside the catheter, to help get the inside hot, or sterile; then as you remove them, you put a clip on the other end.

Question: A plastic Judet femoral head has been inadvertently contaminated, just prior to use. What is the best or accepted method of re-sterilizing this prosthesis for immediate use?

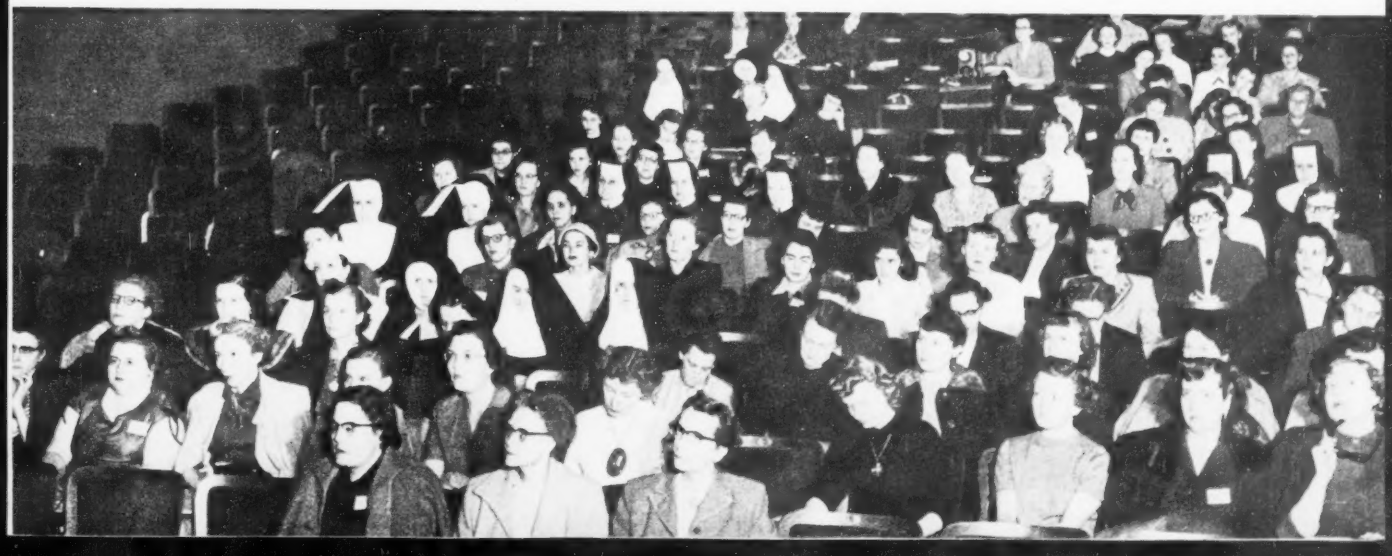
Dr. Walter: I don't know of any way of doing that. The conventional method is to disinfect them by exposure to germicides. Here, I would think the best chemical to use would be 1:1000 Zephiran, containing formalin, and sodium nitrate. At the moment, I cannot remember the amount. The exposure is three hours for satisfactory disinfection for that type of problem.

That does not answer the problem. What happens, if you contaminate it, and the patient's hip is open? Then you have to compromise with your conscience, unless you have another one to use, which would be the ideal situation.

Would a brief immersion in boiling water, containing 2 percent sodium carbonate, three minutes be adequate? I do not believe it would be enough.

Question: Do you feel that the average majority

Below: Overall shot of nurses attending the course on aseptic technic.



of surgeons are qualified to tell us about sterilizing technics? Do they have time and/or the opportunity for research as needed?

Dr. Walter: It has been my experience with surgeons that they know nothing about sterilization and they are opinionated about it. They don't think the problems through at all, or the effects on the operating room as a working unit, or as they affect the teaching and maintenance of a technic in the operating room, which can be used by all people safely.

My own feeling is that this is a field where people such as you are much more qualified to express an opinion and to determine a technic than are the surgeons themselves.

The ideal solution of the problem in each hospital is to have a technic committee, usually made up of the youngest surgeon you can find, who has some time to devote to the problem, and who is given the authority for organizing it, along with the operating room supervisor, to set up what will be the acceptable technic. Then everybody should adhere to the technic, for the sake of economy, and also for the sake of the patient who is being treated.

Question: In making up the laparotomy packs, you mentioned spraying them with distilled water. Why do you use distilled water?

Dr. Walter: Largely because tap water has so many salts in it, which make the linens crusty, and plug the nozzle of the atomizer.

Question: What is the plastic that you use on the end of the syringe?

Dr. Walter: Ordinary polyvinyl chloride, heat resistant.

Question: What do you call an exceptional detergent for cleaning?

Dr. Walter: That varies a great deal with the water supply. The non-ionizing detergents, such as Tide, or Joy, are probably as good as you can get in the field. Remember not to use them in too high a concentration, and to rinse well after use.

CLOSING REMARKS

If there is no other discussion, I should like to close my ramarks by pointing out to you that the big problem in sterilization is to destroy bacteria. We know the temperature, and the time required, and I would like to make a plea for a group such as this to clarify their thinking in the field and get together on simple standards, to gain respect from the profession, for a basic body of knowledge in the field, to make teaching easier and to effect some type of standardization at the hospital.

It is perfectly foolish to think that one hospital can operate for years, with one sterilizing period of 30 minutes, at 250 degrees, for everything, and other hospitals have a list as long as your arm, and it takes about six weeks' indoctrination to tell the various attendants what goes where and why and how, and everything is confusion. Furthermore, when doctors go from one hospital to another, everybody does something different, and you can't blame them for beginning to be skeptical, and wonder if anybody knows anything about the field at all.

Much of the confusion has been due to the fact that the people who manufacture sterilizers all like to have a talking point, for their set-up of technic, and perpetuate a very complicated, elaborate ritual, for packaging and wrapping and sterilizing big and little bundles. Others have introduced very tricky thermometers, which are reputed to give you lower temperatures in the sterilizers than are actually used. Others have got one kind or other of control.

All of them carefully keep from being common in their technic, so that they have competitive advantages on bidding for sterilizers, and it introduces hazards to the patients, and confusion to those who have got to teach nurses and train attendants.

I think that it is only by people in groups such as this one recognizing what the bacteriological facts are, and going on to a simple technic which is easy to teach and will bring safety to the patient, which will give us in the long run standardized products that can be used wherever one may be, simply and easily.

That is one of the things that a group such as this can accomplish, and your thinking should not be fooled by all kinds of advertising claims.

Question: Can you suggest any way to go about it? The surgeons don't recognize us as a group, and we are quite young as a group.

Dr. Walter: All you can do is keep pointing out facts and keep talking the truth and get rid of the confusion in your own thinking. The more you people are confused, the longer the profession stays confused.

Question: When you speak about reading this and that, do you mean that something has been written by other doctors, or the manufacturers?

Dr. Walter: I put out a book once, and in that book there are a lot of references; you can get them if you want to. Or, you can go to the U. S. Pharmacopoeia, and get the official standard for steam sterilization. There are a lot of ways of getting at this, without just going through the advertising literature in the field.

Question: Do you think that we can get the surgeons to read it?

Dr. Walter: You have more chance of getting them to read a textbook than a lot of advertising brochures.

Question: How does one sell the surgeon the idea that the operating room nurse is efficient, rather than officious?

Dr Walter: I suppose, largely by being efficient.

Question: How do you feel these boundaries could be broken?

Dr. Walter: By giving him service, which is right, and which goes along so well that he doesn't have to pay any attention to it, and thus avoiding jangles.

A MATTER OF RESPECT

I believe that efficiency and officiousness are usually just a matter of respect. You respect efficient people, largely because they are never caught off base; they are there when you want them, and they get things done. And, pretty soon, you have a lot of faith and you naturally depend upon them. Maybe that person can give out a lot of guff, to get the job done, and everybody thinks it is wonderful. Along with the officiousness, there is also a performance commanding respect, and a certain reliability.

Then, take the person who makes all kinds of boners, and doesn't run a good department; everybody finds that her end of the stick is dragging every day. She can't be officious or hand out any guff, because she already has strikes against her.

However, if you give efficient service, you can command respect, and you will get to the point where you can talk with people back and forth about problems without giving the impression that you are officious.

There is a lot of difference between knowing your stuff, factually, and turning that knowledge into service which is smooth and efficient and commands respect.

The O.R. Problem Clinic

by EDITH DEE HALL R.N.

● A page set aside for the discussion of administrative problems in the O.R.

The Bone Bank

Bone banks in hospitals probably are second in number to blood banks. Since the procedure of setting up a bone bank is not too difficult, many hospitals can have this service. The following article was written from material submitted by Frances Resser, R.N.

● Bone is collected and stored under aseptic conditions in a deep freeze unit or bone bank. Bone may be preserved and its sterility maintained over a long period of time. Having homogenous grafts ready when needed enables the surgeon to shorten his operative time and the patient to have a more speedy convalescence.

Identification tags, labels, and a card file are necessary equipment for keeping accurate records on bone. The deep freeze unit is kept at 12 to 25 degrees C., and a bone bank pack is kept sterile and ready to receive bone. This pack consists of two bottles capped one inside the other, a test tube, and a Diack control.

A special sterile table is set with a wooden block and orthopedic instruments to shape and prepare the bone. Usually a doctor takes care of this procedure.

Bone is obtained from rib resections done for better exposure in surgery, from amputations resulting from injury, or from any removed bone which has a negative report for any evidence of disease.

DONOR PROCEDURE

1. Bone bank pack is opened by the circulating nurse.
2. The instrument nurse removes the inner bottle and cultures both bottles.
3. Bone is received in a sterile towel from the surgeon, and is thoroughly cultured by rotating swab around the ends and length of bone.
4. Culture tube is given to the circulating nurse, who immediately labels culture, gives it a bone bank number, and sends it to laboratory by messenger.
5. Bone is placed in bottle. If bone is too large, it should be held with forceps and cut to fit in bottle. Small bottle is capped and placed in larger bottle. Lid is tightened securely and bottle handed to circulating nurse.
6. Circulating nurse tags bottle, gives bone bank number (same as number on culture request), records number in file, and places bone in deep freeze unit.

RECIPIENT PROCEDURE

1. Bone is selected by the surgeon and allowed to thaw at room temperature, two hours prior to operation.
2. Culture report is checked by the surgeon.
3. Tag on bone is checked for proper identification.
4. Circulating nurse opens the large bottle, and gently and carefully drops the small bottle into the cupped hands of the instrument nurse.
5. Surgeon prepares the bone on sterile wooden block.
6. After the operation, information from the tag is transferred to the card index.

The Blood Vessel Bank

● Newest of the banks is the blood vessel bank, which provides living arteries for grafting. At present only a few leading hospitals have established such banks.

After a great deal of research to perfect a means of preserving living blood vessels, a preservative consisting of a number of carefully calculated inorganic salts and human blood serum was developed. A buffer solution was added, and antibiotics were injected to prevent infection of the graft.

Grafts are stored in separate glass bottles which have been sterilized. The bottles are closed with sterile rubber stoppers and placed in a bank in which the temperature is just above freezing. With this method, grafts are kept from four to six weeks. Before they are used, they are checked for contamination.

Grafts are removed in the operating room, within four to five hours after death, under the strictest aseptic technic. They are obtained from patients killed in automobile or other accidents. Extensive tests are made for any evidence of disease which would make the graft unusable.

Blood vessels from banks have been used successfully in cases of coarctation of the aorta and in accident cases in which essential arteries were injured.

Below: Gertrude Morawczynski, R.N., (l.) and Dionysia Arabian, R.N., demonstrate how the circulating nurse opens the bone bank pack for the instrument nurse.

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(Additional classified on pages 51, 52)

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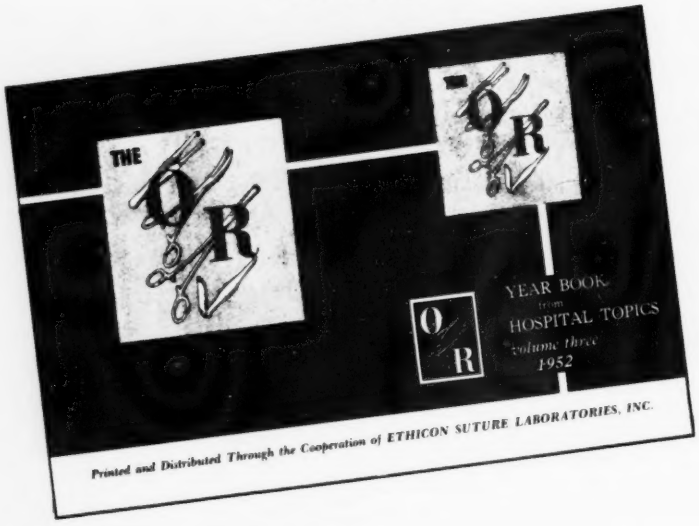

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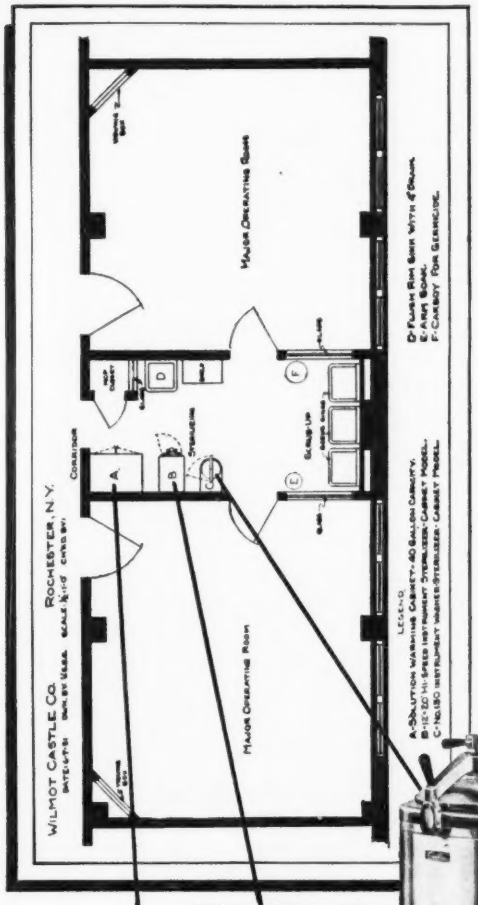

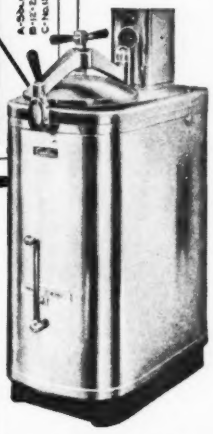

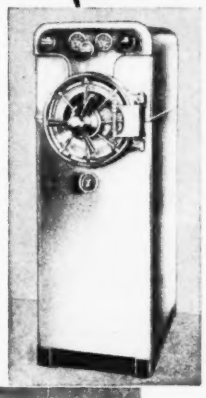

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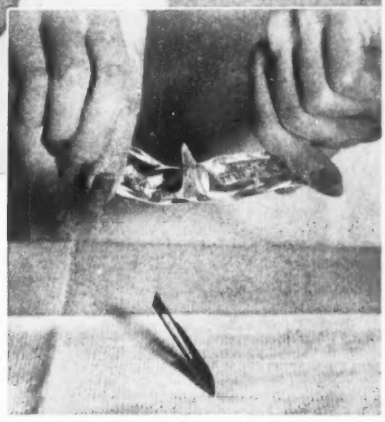

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(1) Riser, A. B.; Kahn, S. S.; Pardue, W. O., and Lawrence, W. E.: Mercurial Diuretics in the Treatment of Congestive Heart Failure, Am. Pract. & Digest Treat. *2*:15, 1951.
(2) Levokove, E., and Sarrow, L. A.: Treatment of Chronic Congestive Heart Failure with a New Meralluride (Mercuhydrin) Suppository, New York State J. Med. *51*:1410 (June 1) 1951.

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